MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10185

CERTIFICATE OF DEATH

10145

Reg. Dist. No. 25

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Pk.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 219 Eighth Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
d. STREET ADDRESS: 219 Eighth Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ORUM Middle S. Last ADAMS

4. DATE OF DEATH: Month 10/13/57 Day Year 19

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/26/95
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10b. KIND OF BUSINESS OR INDUSTRY: F M C
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry F.
14. MOTHER'S MAIDEN NAME: Mary V. Sterling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family - Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adenosarcoma of Duodenum — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Pancreas & Kidney
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary Insufficiency
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jul 27, 1953 to Oct 13, 1957 that I last saw the deceased alive on 10-13, 1957, and that death occurred at 1 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis J Glass M.D. — ADDRESS (Street, city or town, state): 320 Patapsco Ave — DATE SIGNED: Oct 14-57
PHYSICIAN'S NAME (Type): DR LOUIS J. GLASS — Balto #25 - md.

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: 10/16/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully Funeral Homes - 130 E. Fort Avenue
24a. REC'D BY REGISTRAR DATE: OCT 16 1957
24b. REGISTRAR'S SIGNATURE: Ida Watson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10148 10146

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 2 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.N.Hospital, Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 6 Kent Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Greene Last: ATWOOD Jr.

4. DATE OF DEATH: Month: Oct Day: 13 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11 July 1943

9. AGE (In years last birthday): 14 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Robert Greene ATWOOD

14. MOTHER'S MAIDEN NAME: Lois H. HILL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: - - -

17. INFORMANT — Address: U.S.N. Hospital, Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MASSIVE CONFLUENT BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: One week
DUE TO (b): STAPHLOCOCCUS AUREUS
DUE TO (c):

491 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9 Oct. 1957 to 13 Oct. 1957 that I last saw the deceased alive on 13 Oct. 1957, and that death occurred at 5:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert G Brown Jr Lt/MC/USNR M.D. ADDRESS (Street, city or town, state): U.S.N. Hospital, Annapolis, Md. DATE SIGNED: 14 Oct 1957

PHYSICIAN'S NAME (Type): For: M. J. MILLER LT MC USNR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-17-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county): Arlington (State): Va

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: 10/15/57 24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10147

10149

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Academy Asst.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1 Spa View Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Caroline — Middle — Last Bernstein

4. DATE OF DEATH: Month 10 — Day 9 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-23-1879

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Mr Brown

14. MOTHER'S MAIDEN NAME: Karoline Müller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: John Bernstein — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week

420.0

DUE TO (b): Arteriosclerotic Heart Disease — 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cholecystitis acute with Cholelithiasis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 10, 1950 to Oct. 9, 1956, that I last saw the deceased alive on 10-9-1957, and that death occurred at 9:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.

ADDRESS (Street, city or town, state): 6 SHAW ST. ANNAPOLIS, MD

DATE SIGNED: 9-10-57

PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-12-57

22c. NAME OF CEMETERY OR CREMATORY: St Mary's

22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Layfield Sons

ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 10/11/57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10:86

CERTIFICATE OF DEATH

10148

Reg. Dist. No. 78

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 9ys,1mo,13ds.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Vol. 4
d. STREET ADDRESS: 726½ W. Saratoga Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosalie — Middle: Bethea — Last:
4. DATE OF DEATH: Month: 10 — Day: 29 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/12/1900
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ———
(If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO.: ———
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suppurative Peritonitis — INTERVAL BETWEEN ONSET AND DEATH:
626X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Gangrenous recto-vaginal fistula
DUE TO
(c): Old Hysterectomy

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenia, Paranoid Type
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED: White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 16, 1948, to October 29, 1957, that I last saw the deceased alive on October 29, 1957, and that death occurred at 11:58PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 10/29/57
PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/3/1957
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
22d. LOCATION (City, town, or county) (State): ~~Balto~~ A.A. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: C. O. Wilson — ADDRESS: 1000 Brantley Ave
24a. RECD BY REGISTRAR DATE: NOV 4 1957
24b. REGISTRAR'S SIGNATURE: A. Mayer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (d) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10149

10187 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: AA. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
c. LENGTH OF STAY IN 1b: 31 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 603 E. Maple Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
d. STREET ADDRESS: 603 E. Maple Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Carrie Middle May Last Bierman

4. DATE OF DEATH: Month Oct. Day 19 Year 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan 24 1868
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Alexandria Va
12. CITIZEN OF WHAT COUNTRY?: —

13. FATHER'S NAME: James R. Cole
14. MOTHER'S MAIDEN NAME: Melissa Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None.
17. INFORMANT: Albert Bierman (Name) Address (Street) son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-Vascular Disease
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 8-10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____ 1938 to 10/19 1957 that I last saw the deceased alive on 10/19/57 19____, and that death occurred at 11:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. L. Ball Jr. M.D.
ADDRESS (Street, city or town, state): Linthicum Md
DATE SIGNED: 10/19/57
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 22/57
22c. NAME OF CEMETERY OR CREMATORY: Western
22d. LOCATION (City, town, or county) (State): Baltimore, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Witzke Funeral Director, ADDRESS: 4101 Edmondson Ave
24a. REC'D BY REGISTRAR DATE: OCT 22 1957
24b. REGISTRAR'S SIGNATURE: A. W. Heduck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10188

CERTIFICATE OF DEATH

10150

Reg. Dist. No. 18

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 3 mos. 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 9 Pace's Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: David — Last: Bishop

4. DATE OF DEATH: Month: 10 — Day: 3 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/28/1888

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Ollie Bishop

14. MOTHER'S MAIDEN NAME: Hester

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: ------

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Hypertensive Cardiovascular Disease

DUE TO

(c) Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paraplegia amaurosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): ----------

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: ------ 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. I certify that I attended the deceased from June 28, 1957, to October 3, 1957, that I last saw the deceased alive on October 3, 1957, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 10/3/57

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): ----------

22b. DATE THEREOF: 10/5/57

22c. NAME OF CEMETERY OR CREMATORY: Madison Cemetery

22d. LOCATION (City, town or county) (State): Dorchester Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: H. M. H. Claire — ADDRESS: 317 High Street Cambridge Md.

24a. RECEIVED BY REGISTRAR (Date): OCT 1 1957

24b. REGISTRAR'S SIGNATURE: A. M. Hayes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10151

10189 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg Dist No 24

1 PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: All life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Jumper Hole Rd.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward Middle A. Last Bolm

4. DATE OF DEATH: Month October Day 19th Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/31/06

9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pasadena, M.d.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl Bolm

14. MOTHER'S MAIDEN NAME: Eleanore Meyers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. Georges Bolm (brother) Address: Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ___

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ a.m. p.m. Month, Day, Year ___ 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒, and in my opinion death resulted from Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10/16/57

EXAMINER'S NAME (Type): Gustavo H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/18/57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town or county) (State): Baltimore 25, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping & Kirkley, Glen Burnie, Md.

ADDRESS

24a. REC'D BY REGISTRAR: OCT 21 1957

24b. REGISTRAR'S SIGNATURE: L. P. Stallings

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the [redacted] and file Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the [redacted] Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A 1ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10150

10152

CERTIFICATE OF DEATH

Reg. Dist No. 21

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arund. General Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenburnie
d. STREET ADDRESS: — — —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY Middle — Last BOSCHERT.

4. DATE OF DEATH: Month 10 Day 2 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 19, 1888

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Henry Punta

14. MOTHER'S MAIDEN NAME: Gertrude (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): — —

16. SOCIAL SECURITY NO: None

17. INFORMANT: William J. Boschert Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): SUBARACHNOID HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS

330X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): RUPTURED ANEURYSM OF BASILAR

DUE TO (c): ARTERY — INDETERMINATE.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10/1 19 57 to 10/2 19 57 that I last saw the deceased alive on 10/3 19 57 and that death occurred at 12:58 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N. Peeler M.D. ADDRESS (Street, city or town, state): 68 Franklin St. DATE SIGNED: 10/2/57.

PHYSICIAN'S NAME (Type): RICHARD N. PEELER Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 7, 1957

22c. NAME OF CEMETERY OR CREMATORY: Our Lady of the Fields Cem.

22d. LOCATION (City, town, or county) (State): Millersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: T. Livingston ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: OCT 8 1957

24b. REGISTRAR'S SIGNATURE: Wm J Tierney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10190

CERTIFICATE OF DEATH

10153
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 24 yrs, 6 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 544 St. Mary's
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vina — Middle: — Last: Brooks
4. DATE OF DEATH: Month: 10 — Day: 8 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 54 yrs.
If UNDER 1 YEAR: Months: — Days: — If UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Basil Brooks
14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ———
(If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO.: ———
17. INFORMANT: Hospital Records — Address: ———

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis — INTERVAL BETWEEN ONSET AND DEATH:
5'10.5
DUE TO
(b): Partial Intestinal Obstruction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO
(c): ———

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental Deficiency - Imbecile
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): ———
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year ——— 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———
20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from 4/8/ 19 33 to 10/8 19 57 that I last saw the deceased alive on 10/8 1957, and that death occurred at 9:30A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp, M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 10/8/57
PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): ———
22b. DATE THEREOF: 10-10-57
22c. NAME OF CEMETERY OR CREMATORY: U. Md. Med. School
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Wise #102 West St. Annapolis
ADDRESS:
24a. REC'D BY REGISTRAR DATE: 10-10-57
24b. REGISTRAR'S SIGNATURE: J. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician for completion. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10191

10154

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. b. COUNTY: Somerset

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.

c. LENGTH OF STAY IN 1b: 20 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Lester; Middle:; Last: Brown

4 DATE OF DEATH: Month: 10; Day: 7; Year: 19 57

5 SEX: Female

6. COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/16/16

9 AGE (In years last birthday): 41 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic Worker

10b. KIND OF BUSINESS OR INDUSTRY: ———

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Noah Henry Brown

14. MOTHER'S MAIDEN NAME: Fannie Finney

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ———
(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO: ———

17 INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Hyperthyroid Condition — since admissic

DUE TO

(c): — 9/17/57

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Involutional Psychosis

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY: Hour a. m. p. m. ——— Month, Day, Year ——— 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f (City or town) (County) (State): ———

21. I certify that I attended the deceased from 9/17/57, 19—, to 10/7, 1957, that I last saw the deceased alive on 10/7, 19 57, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp, M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 10/7/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/13/57

22c. NAME OF CEMETERY OR CREMATORY: St Mary

22d. LOCATION (City or town, or county) (State): West Post Office md

23. FUNERAL DIRECTOR'S SIGNATURE: William H. Jones Jr

ADDRESS: Crownsville, Md.

24a REC'D BY REGISTRAR DATE: OCT 15 1957

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician (or by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10192

CERTIFICATE OF DEATH

10155

Reg. Dist. No. 24

1 PLACE OF DEATH
a. COUNTY: Annie Arundle — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenburnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Plaza Manor Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2128 N.Pulaski Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MINNIE; Middle:; Last: CALVERY

4. DATE OF DEATH: Month: October; Day: 23; Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: September 16,1882

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Virginia;Lancaster Co.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Weinburg

14. MOTHER'S MAIDEN NAME: Lettie Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ernestine Williams — Address: 247 N.Kentucky Avenue Atlantic City,New Jersey

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Metastatic Carcinoma Lungs — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO (b): Crcinoma Uterus — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 20 19.57, to October 23 19.57, that I last saw the deceased alive on October 20, 1957, and that death occurred at 4 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Pair M.D.

ADDRESS (Street, city or town, state): 400 N. Carrollton Avenue Baltimore 23, Maryland

DATE SIGNED:

PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.26,1957

22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Park

22d. LOCATION (City, town, or county) (State): Hays Landing,New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: Elroy O.Wilson

ADDRESS: 1000 Brantley Avenue

24a. REC'D BY REGISTRAR DATE: 10/29/57

24b. REGISTRAR'S SIGNATURE: L. V. Bradley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10193 **CERTIFICATE OF DEATH**

10156 Reg. Dist. No. 4-18

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN Hospital: 1yr,7mo,3ds.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgley
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Ella — Middle: — Last: Carney

4 DATE OF DEATH: Month: 10 — Day: 30 — Year: 19 57

5 SEX: Female

6 COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Unknown

9 AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b KIND OF BUSINESS OR INDUSTRY: —

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY: U. S. A.

13 FATHER'S NAME: Unknown

14 MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):

16 SOCIAL SECURITY NO:

17 INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 10/28/57
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis — since admission
DUE TO
(c)

4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.):

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3/27/56, 19__, to October 30, 19 57, that I last saw the deceased alive on October 30, 19 57, and that death occurred at 9:50P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 10/30/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 4, 1957
22c. NAME OF CEMETERY OR CREMATORY: Denton Md
22d. LOCATION (City, town, or county) (State): Denton Md

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond C. Rawlings
ADDRESS: Denton Md

24a. REC'D BY REGISTRAR DATE: 11/4/57
24b. REGISTRAR'S SIGNATURE: L. Mae Pippen
H. M. Goyette

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page[illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10157

10194 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First LAURA Middle P. Last DAWSON CARR
4. DATE OF DEATH: Month OCTOBER Day 15 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: October 26, 1877
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Mayo, Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Nicholas G. Collison
14. MOTHER'S MAIDEN NAME: Susan Hubbard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs Alvin Owens- Daughter- Address: same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH
153 x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS A TOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956 to Oct 15, 1957, that I last saw the deceased alive on Oct 15, 1957, and that death occurred at 7 P. M., from the causes and on the date stated above

ACTUAL SIGNATURE: Emily H. Wilson M.D. ADDRESS (Street, city or town, state): Harwood Md DATE SIGNED: 10 18 57

PHYSICIAN'S NAME (Type): Emily H. Wilson MD — Harwood, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: October 18, 57
22c. NAME OF CEMETERY OR CREMATORY: Mayo Memorial Cemet.
22d LOCATION (City, town, or county) (State): Mayo, Maryland (A A County)

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a REC'D BY REGISTRAR: OCT 21 '57
24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10158

10195 **CERTIFICATE OF DEATH**

Reg. Dist. No. 24

1 PLACE OF DEATH
a. COUNTY: Anne Arundel Co. — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Glen Burnie Plaza Manor Nursing Home — STREET ADDRESS: 620 N. Monroe Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Louise — Last: Carter

4. DATE OF DEATH: Month: October — Day: 30 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 10, 1907

9. AGE (In years last birthday): 50 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Heathsville, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Allen Young

14. MOTHER'S MAIDEN NAME: Alverta Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO:

17. INFORMANT: Pauline Haywood — Address: 620 N. Monroe Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident, Left hemiparesis 6yrs.

4438

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Arteriosclerotic Cardiovascular Many Yrs.

DUE TO (c): Disease with decompensation and Auricular Fibrillation.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 23 19 57 to October 30 19 57, that I last saw the deceased alive on October 28, 19 57, and that death occurred at 9: A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Pair M.D. — ADDRESS (Street, city or town, state): 400 N. Carrollton Avenue Baltimore 23, Maryland — DATE SIGNED: 10.31.57

PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 3, 1957

22c. NAME OF CEMETERY OR CREMATORY: Edwardsville

22d. LOCATION (City, town or county) (State): Edwardsville, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles R. Law — ADDRESS: 802 Madison Avenue

24a. RECD BY REGISTRAR DATE: NOV 1 1957

24b. REGISTRAR'S SIGNATURE: Louis Dealba

CJ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 X

FOR STATE HEALTH DEPT.

M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10159

Then 7 Fil 0222 11-6-57 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jacobsville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 607 - Hognock Road.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 161 W. Henrietta Street
e. INSIDE CITY LIMITS ON A FARM: YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First O'NEIL, Middle, Last CARTER

4. DATE OF DEATH: Month October, Day 20, Year 19 57

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 15, 1923

9. AGE (In years): 34 yrs. — UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): L

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sam Carter

14. MOTHER'S MAIDEN NAME: Katie Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE: Multiple Traumatic Injuries.
DUE TO: (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.: Pedestrian struck by auto.

20c. TIME OF INJURY: Hour 11:25 P.M. — Month, Day, Year: 10/20 19 57

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): Jacobsville (County): A.A. (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul F Guerin

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 10/21/57

EXAMINER'S NAME (Type): Paul F. Guerin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-26-57

22c. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cemtery

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Isaish L. Brown and Son 108 W. Montgomery St

24a. RECEIVED BY REGISTRAR — DATE: OCT 31 1957

24b. REGISTRAR'S SIGNATURE: Lena C. La Mora

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give reasons in items 1, 2, and 3 to the extent known. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMD. Page 5 may be detached for your files

TO FUNERAL DIRECTOR. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation or removal, and in any event within 72 hours after death

VS A1SME
6M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10151

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10160

Reg. Dist. No. 51

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 50 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANNE ARUNDEL GENERAL
d. STREET ADDRESS (If not in hospital, give street address): BOX 282 RT. 3 (1324 Constitution Ave NE)

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDGEWATER Washington D.C.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LESLIE Middle — Last CICALA

4. DATE OF DEATH: Month OCT. Day 20 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 24, 1921

9. AGE (In years last birthday): 36 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHOEMAKER

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): ITALY Sicily

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DOMENICO CICALA

14. MOTHER'S MAIDEN NAME: GIOVANNA ROSCONA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 578-12-2779

17. INFORMANT: MRS. JEAN CICALA (Address) 1324 Constitution Ave NE Edgewater, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MASSIVE HEMOTHORAX — INTERVAL BETWEEN ONSET AND DEATH: 1 hr. 20 min.

DUE TO (b): FRACTURES OF RIBS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): AUTO ACCIDENT

20c. TIME OF INJURY: Hour 11 a.m. p.m. Month, Day, Year 10/19/1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 214 nr Davidsonville, A.A. Md.

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Jesse L. Wilkins, M.D. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): JESSE L. WILKINS, M.D.

DATE SIGNED: 10/20/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 24, 1957

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town or county) (State): Suitland, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers

ADDRESS: Wash, D.C. 1400 CHAPIN ST N.W.

24c. RECEIVED BY REGISTRAR: DATE OCT 22 1957

24b. REG. STRAR'S SIGNATURE: Mrs. J. Trundy

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10197

CERTIFICATE OF DEATH

10161

Reg. Dist. No. 34

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 4yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3 Amelia Ave (N.E)

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 3 Amelia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAISY Middle MAY Last CLARK

4 DATE OF DEATH: Month OCT. Day 4 Year 1957

5. SEX: F.

6. COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9 Sept 1902

9 AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11 BIRTHPLACE (State or foreign country): KENTUCKY

12 CITIZEN OF WHAT COUNTRY?: Yes-U.S.

13. FATHER'S NAME: ANDREW MOORE (dec.)

14 MOTHER'S MAIDEN NAME: NANCY NOBLE (dec.)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: 403-18-6151

17 INFORMANT: Mrs Mary Ross (Sister) Address 5 Amelia Ave. Glen Burnie, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): Cancer of uterus — 2 yrs
DUE TO
(c): Generalized carcinomatosis — 4 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension - 5 yrs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): no

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. X 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 20f (City or town) Glen Burnie (County) A. Arundel (State) Md.

21. I certify that I attended the deceased from May, 1955, to 4 Oct, 1957, that I last saw the deceased alive on 26 Sept, 1957, and that death occurred at 10:15 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: Hubert F. Manuzak M.D.
ADDRESS (Street, city or town, state): 901 EDGERLY RD - GLEN BURNIE, MD.
DATE SIGNED: 4 Oct. 1957
PHYSICIAN'S NAME (Type): HUBERT F. MANUZAK

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 7-1957
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: OCT 8 1957
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7? Film 3221, 10/10/57 Liv

10160

10188

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1 PLACE OF DEATH a. COUNTY Anne Arundel Gen Hosp Annapolis MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE DC Maryland b. COUNTY Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS 163 East

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) KNOWN AS: ELSIE LYNN CLARK GIGUERE

4 DATE OF DEATH Month 10 Day 2 Year 1957

5. SEX F

6. COLOR OR RACE W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH 10-19-32

9 AGE (In years last birthday) 26 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress

10b. KIND OF BUSINESS OR INDUSTRY 214-26-0624

11. BIRTHPLACE (State or foreign country) Md.

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Delmar Clark

14 MOTHER'S MAIDEN NAME Elsie A. Fugate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Phosphorous Poisoning — INTERVAL BETWEEN ONSET AND DEATH 8 days.

7718

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Suicide intent by phosphorus ingestion — 8 days

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 24, 1957 to Oct 2, 1957 that I last saw the deceased alive on Oct 2, 1957, and that death occurred at 1:14 A.M. from the causes and on the date stated above

ACTUAL SIGNATURE Richard N. Peeler M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S NAME (Type) RICHARD N. PEELER

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF Oct. 5, 1957

22c. NAME OF CEMETERY OR CREMATORY Oak Lawn

22d. LOCATION (City, town, or county) (State) Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LILLY & ZEILER, INC 1931 EASTERN AVE

24a RECD BY REGISTRAR DATE OCT 7 1957

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director page 2 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

Do not issue any copies of this certificate.
Request made by Mrs. Elsie A. Clark
2103 E. Lamley St.
Baltimore 31, Md.

mother of deceased.

11/1/57 cac

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10198

CERTIFICATE OF DEATH

10162

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md. — c. LENGTH OF STAY IN 1b: 5 yrs.4mos.11	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Skidmore, Md.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.	d. STREET ADDRESS: R. F. D. 2, Box 557 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Arie — Middle: — Last: Colbert	4. DATE OF DEATH: Month: 10 — Day: 9 — Year: 19 57
5 SEX: Female — 6. COLOR OR RACE: Negro — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 9/14/01 — 9 AGE (In years last birthday): 56 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic — 10b. KIND OF BUSINESS OR INDUSTRY: ——— — 11 BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY: U. S. A.	
13 FATHER'S NAME: Eligah Henson — 14 MOTHER'S MAIDEN NAME: Gertrude Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ——— (If yes, give war or dates of service) ——— — 16. SOCIAL SECURITY NO ——— — 17 INFORMANT: Hospital Records — Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Emaciation

DUE TO (b): Malnutrition

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 296.5

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic Reaction, Paranoid Type

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) — 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): ———

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. ——— 19 — 20d INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ——— — 20f. (City or town) (County) (State) ———

21. I certify that I attended the deceased from May 28, 1952, to October 9, 1957, that I last saw the deceased alive on October 9, 1957, and that death occurred at 9:26a.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp, M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 10/10/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 10-13-57	22c. NAME OF CEMETERY OR CREMATORY: Odd Fellows	22d LOCATION (City, town, or county): Skidmore (State): Md.	
23. FUNERAL DIRECTOR'S SIGNATURE: Wilkerson Funeral Home	ADDRESS: 108 Wash. Ave. Annapolis, Md.	24a REC'D BY REGISTRAR DATE: 10/14/57	24b. REGISTRAR'S SIGNATURE: H. M. Myers	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10153 Items 1-2 filled 10-10-57 et 10163

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY: A. A. County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ----

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE: Maryland b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Riva
d. STREET ADDRESS: 146 Besgate Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First John Middle G. Last Colbert
4 DATE OF DEATH: Month 10 Day 1 Year 1957

5 SEX: Male
6 COLOR OR RACE: Colored
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-7-1957
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months 4 Days | IF UNDER 24 HRS.: Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Riva, Md. (See Birth Cert.)
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Josiah Colbert
14. MOTHER'S MAIDEN NAME: Shirley Griffith

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17 INFORMANT: Shirley Colbert Address: 146 Besgate Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 13 days.

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b): c Malnutrition & Dehydration & Diarrhea
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 10/1/57 19____ to ____ 19____ that I last saw the deceased alive on 10/1/57 19 57, and that death occurred at 11 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore H. Johnson M.D. ADDRESS (Street, city or town, state): 37 Cathedral St. DATE SIGNED:
PHYSICIAN'S NAME (Type): Dr Theodore H. Johnson Annapolis, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 10-3-57
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d LOCATION (City, town, or county) (State): Annapolis Md

23 FUNERAL DIRECTOR'S SIGNATURE: William Reese ADDRESS: #108 Wash St
24a REC'D BY REGISTRAR DATE: OCT 3 1957
24b REGISTRAR'S SIGNATURE: Wm. J. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out by the funeral director page 2 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

27

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10153 Item 2 F[illegible] [illegible]-57 ct

CERTIFICATE OF DEATH

10164

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH — a. COUNTY: A. A. County — MARYLAND; b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis; c. LENGTH OF STAY IN 1b:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland; b. COUNTY: A. A.; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riva

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

d. STREET ADDRESS: 146 Bestgate Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Shirley; Middle: ann; Last: Colbert

4 DATE OF DEATH: Month: 10; Day: 1; Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-7-1957

9 AGE (If over 1 year last birthday) yrs: 4 — IF UNDER 1 YEAR: Months; Days; IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Riva, Md. (See Birth Cert.)

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Josiah Colbert

14 MOTHER'S MAIDEN NAME: Shirley Griffith

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: Shirley Colbert — Address: 146 Bestgate Rd.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bilateral Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 13 days

491 ✗

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) ✗ Malnutrition ✗ Dehydration ✗ Anemia — 18 days

DUE TO (c)

PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10/1/57, 19____, to ____, 19____, that I last saw the deceased alive on 10/1, 1957, and that death occurred at 12:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore H. Johnson M.D — ADDRESS (Street, city or town, state): 37 Cathedral St. Annapolis, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. THEODORE H. JOHNSON.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-3-1957

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hall

22d LOCATION (City, town or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II — ADDRESS: 108 West Street

24a. REC'D BY REGISTRAR, DATE

24b. REGISTRAR'S SIGNATURE: Wm J. Friendly

VS A15 (4) 15M 9 55

183XV3

E5

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10154

CERTIFICATE OF DEATH

10165

Reg. Dist. No.

M

1 PLACE OF DEATH a. COUNTY A.A. Co. MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY A.A. Co.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. General Hospt.

d. STREET ADDRESS 10 MUNROE COURT

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ARTHUR Middle W. Last CONDELL

4 DATE OF DEATH Month 10 Day 1 Year 1957

5 SEX MALE

6. COLOR OR RACE WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 1-23-1896

9 AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD Ret.

10b. KIND OF BUSINESS OR INDUSTRY Civil SERVICE

11 BIRTHPLACE (State or foreign country) CHICAGO, ILL

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME ARTHUR CONDELL

14 MOTHER'S MAIDEN NAME "UNK"

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1913-1924

16. SOCIAL SECURITY NO

17. INFORMANT ESTHER CONDELL Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH Short ?

DUE TO (b) Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-1-52, 19 57 to 10-1-52, 19 52, that I last saw the deceased alive on 10-1-52, 19 52, and that death occurred at 8:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE John R. Martin M.D.

ADDRESS (Street, city or town, state) 6 SHAW ANNAPOLIS, MD

DATE SIGNED 10/3/57

PHYSICIAN'S NAME (Type) JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 10-4-57

22c. NAME OF CEMETERY OR CREMATORY CEDAR Bluff

22d. LOCATION (City, town, or county) ANNAPOLIS (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons

ADDRESS Annapolis, Md.

24a REC'D BY REGISTRAR DATE 10/4/57

24b. REGISTRAR'S SIGNATURE U. Unnumbered

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

1

10199 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10166

Item 2 - See [illegible] Reg. Dist No. 21

1. PLACE OF DEATH a. COUNTY AA.CO. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Annapolis
c. LENGTH OF STAY IN 1b 2 MONS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE MD b. COUNTY AACO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS R.F.D. St. Margrets
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Dino Middle Last Cook
4. DATE OF DEATH Month 10 Day 22 Year 1957
5. SEX Male
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug. 2, 1957
9. AGE In years Last birthday 2 MONS
IF UNDER 1 YEAR Months 2 Days
IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) St Tiladelphia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Alfred Le Johnson
14. MOTHER'S MAIDEN NAME Dora Cook
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Gladis Cook St. Margrets

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Vomitus — INTERVAL BETWEEN ONSET AND DEATH Instant
921.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Aspirated vomitus while feeding on bottle
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) St. Margarets (County) AA (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Linhurst M.D.
EXAMINER'S NAME (Type) E. Linhurst
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 10/24/57

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF Oct 24 1957
22c. NAME OF CEMETERY OR CREMATORY Broadneck
22d. LOCATION (City, town, or county) St. Margrets (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE Arnold E. Johnson ADDRESS Annapolis
24a. REC'D BY REGISTRAR DATE OCT 24 1957
24b. REGISTRAR'S SIGNATURE L. W. J. French

THE COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Form 5 may be [illegible] for [illegible]. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record of death or prior to burial, cremation, removal.

VS. AISME(5) SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10200 10167

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 5, First Copy Only

Reg Dist No 24

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): P.O. Pasadena
c. LENGTH OF STAY IN 1b: 10 y.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Poplar Ridge

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IF FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Hilda — Middle May — Last Cooke

4 DATE OF DEATH: Month October — Day 20th. — Year 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/14/11
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John P. Lottier
14. MOTHER'S MAIDEN NAME: Carrie M. Waterman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Mr. John E. Cooke (husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio vascular diseases — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b):
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY: Hour — a. m. / p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE, M.D.: Gustave H. Faubert M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gust ve H. Faubert, M.D.
DATE SIGNED: 10/22/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-23-57
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Singleton Funeral Home, Glen Burnie, Md.
24a. RECD BY REGISTRAR DATE: OCT 4 1957
24b. REGISTRAR'S SIGNATURE: Lawrence J. DeAlba C I

TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be used for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1SME SM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10168

10155

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISME(S)
SM 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md. — b. COUNTY: A.A.C.o.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 406 Severn Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospt.

3. NAME OF DECEASED (Type or print): First: Neva — Middle: Kent — Last: Cronin

4. DATE OF DEATH: Month: 10 — Day: 27 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-6-1882

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME

10b. KIND OF BUSINESS OR INDUSTRY: HOME WIFE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Etheridge Kent

14. MOTHER'S MAIDEN NAME: Mary Ann Chance

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Julia Kent — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Fracture Hip Left — INTERVAL BETWEEN ONSET AND DEATH: 16 days

DUE TO (b): Pneumonia Hypostatic

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Fell in bath room

20c. TIME OF INJURY: Hour (a.m. p.m.) — Month, Day: 10/6 — Year: 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Ann — (County): Ann — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐ Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10/22/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-27-57

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest

22d. LOCATION (City, town, or county): Annapolis — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Poland Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: 10/24/57

24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10201 **CERTIFICATE OF DEATH** Reg. Dist. No. 10169

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 4 ys. 10 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 20 Water Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Pearl — Middle: — Last: Curry

4 DATE OF DEATH: Month: 10 — Day: 17 — Year: 1957

5 SEX: Female

6 COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 2/2/27

9 AGE (In years last birthday): 30 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dishwasher

10b. KIND OF BUSINESS OR INDUSTRY: ———

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William Curry

14. MOTHER'S MAIDEN NAME: Mamie

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ——— (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO: Unknown

17 INFORMANT: Hospital Records — Address: ———

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pneumonia - Bilateral Lobar — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
490 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ———
DUE TO
(c) ———

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. ——— Month, Day, Year 19 ———

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from November 21, 1952 to October 17, 1957, that I last saw the deceased alive on October 17, 1957, and that death occurred at 7:25 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 10/17/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-21-57
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, Ft. Anne. Md. — ADDRESS

24a. REC'D BY REGISTRAR DATE: 10/22/57
24b. REGISTRAR'S SIGNATURE: A. M. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

[illegible]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The original or a copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1 55 10M

Item 9, Film G221, 10/24/57 fcy

10170

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10202

Reg. Dist. No.

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR CONVAL. HOME

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
STREET ADDRESS (If rural give location) 527 N. CAREY ST.

3. NAME OF DECEASED (Type or Print) (First) GLADYS (Middle) T. (Last) Dadd.

4. DATE OF DEATH (Month) Oct (Day) 9 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	C	SINGLE	AUG. 25, 1890	67 Yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNEMPLOYED		VIRGINIA, NEWPORT NEWS	U.S.A

13. FATHER'S NAME: NONNIE C. DADD
14. MOTHER'S MAIDEN NAME: MARY P. [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO		LINCOLN S. DADD 527 N. CAREY ST

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) CORONARY THROMBOSIS

ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic heart disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County, (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1956, to Oct 9, 19 57, that I last saw the deceased alive on Oct, 19 57, and that death occurred at 5:00 A M, from the causes and on the date stated above.

SIGNATURE Joseph Cafe M.D. ADDRESS (Street, city, town, state) 102 BALTIMORE BLVD, N.E. Glen Burnie, Md. DATE SIGNED 10-9-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	10/12/57	ARLINGTON MEM PK.	ARLINGTON, VA. (Co.) MD

24. RECD BY REGISTRAR DATE OCT 9 1957
REGISTRAR'S SIGNATURE J. C. Bailey
25. FUNERAL DIRECTOR'S SIGNATURE Elroy A. Wilson ADDRESS 1006 Broadway

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10203 — 10171 — 58

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville RD

LENGTH OF STAY (In this place) 1 day

HOSPITAL OR INSTITUTION OR STREET ADDRESS 949 Tudor Drive, Sunrise Beach

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE District of Columbia — COUNTY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington DC - #27

STREET ADDRESS (If rural give location) 4908 Alton St.

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) — (Last) Damico

4. DATE OF DEATH (Month) Oct. (Day) 12, (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min
Male	White	Married	March 26, 1898	59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bricklayer (ret)	Anthony Izza, Inc.	Italy	U.S.A.

13. FATHER'S NAME: Luigi Damico

14. MOTHER'S MAIDEN NAME: Emelia (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) Yes No. [redacted] — —

16. SOCIAL SECURITY NO: Unknown...

17. INFORMANT & ADDRESS: Mrs. Emma Damico Same As #2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 IMMEDIATE CAUSE (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 Min

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Oct 12 '57 to Oct 12 '57 — I last saw the deceased alive on Oct 12 '57 — Death occurred at 2:20 P.M., from the causes and on the date stated above.

SIGNATURE Edward J. Smith M. D. — ADDRESS (Street, city, town, state) Gambrills Md — DATE SIGNED 10-13-57

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 16/57	Cedar Hill cem.	Brooklyn PRD., Md.

24. REC'D BY REGISTRAR DATE OCT 16 1957	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
	F. M. Joyce	R. V. Singleton	Glen Burnie, Md.

Tax Exempt Transferred to Chambers Funeral Home, Wash D.C.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10156

CERTIFICATE OF DEATH

10172

Reg. Dist. No. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 35 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Vineyard Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HUGO — Middle — Last DICKHOFF

4. DATE OF DEATH: Month October — Day 8, — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 23, 1875

9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ACCOUNTANT: Retired

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Berlin, Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EMIL DICKHOFF

14. MOTHER'S MAIDEN NAME: MATILDA STOMMEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-03-0793A

17. INFORMANT — Address: Mrs. Gertrude Tucker, Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): leakage following abdomino-perineal resection of rectum and sigmoid colon
DUE TO (c): Adeno-carcinoma of rectum

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma left kidney and generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9-25- 1957 to 10-8- 1957 that I last saw the deceased alive on 10-8- 1957, and that death occurred at 12 M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Jesse L. Wilkins M.D. — ADDRESS (Street, city or town, state): 98 Cathedral St. — DATE SIGNED: 10-9-57

PHYSICIAN'S NAME (Type): JESSE L. WILKINS, M.D. — Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10-12-57

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

22d. LOCATION (City, town, or county) (State): Prince George County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hopping Funeral Home Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: OCT

24b. REGISTRAR'S SIGNATURE: Wm. J. Hirsch

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10204 CERTIFICATE OF DEATH

Reg. Dist. No. 10173

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2yrs 10mos
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
d. STREET ADDRESS: R.F.D
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: George — Middle: Edward — Last: Dicksen

4 DATE OF DEATH: Month: October — Day: 18 — Year: 1957

5 SEX: Male

6. COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ UNDIVORCED ☐

8 DATE OF BIRTH: Unknown

9 AGE (In years last birthday): 67 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Unknown

12 CITIZEN OF WHAT COUNTRY? U.S.A

13 FATHER'S NAME: Unknown to us

14 MOTHER'S MAIDEN NAME: Unknown to us

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): Apr 30, 1918 - July 7, 1919

16. SOCIAL SECURITY NO.:

17 INFORMANT: Hospital Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH:

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Thrombophlebitis — 17 days

DUE TO (c): Generalized Arteriosclerosis — 2yrs 10mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Dec 2, 1954, to Oct 18, 1957, that I last saw the deceased alive on October 18, 1957, and that death occurred at 7:45 P. M., from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Crownsville Md. — DATE SIGNED: 10/18/57

PHYSICIAN'S NAME (Type): Ludwig Benedict

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-22-57

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or county) (State): Selbyville Delaware

23 FUNERAL DIRECTOR'S SIGNATURE: Charles E. Heist III — ADDRESS: 43 north st ANNAPOLIS MD

24a. REC'D BY REGISTRAR DATE: 10/23/57

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10174

10205 Item 9 Film 6222 11-1-57 et

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie

LENGTH OF STAY (In this place) 3yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 St James Drive

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie

STREET ADDRESS (If rural give location) 104 St James Drive

3. NAME OF DECEASED (Type or Print) (First) Dorothy (Middle) E. (Last) Donaldson

4. DATE OF DEATH (Month) Oct (Day) 23 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Female	White	Married	Feb 9, 1921	36 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Domestic	Maryland	U.S.A.

13. FATHER'S NAME Robert Goette

14. MOTHER'S MAIDEN NAME Daisy Titchnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	?	James Donaldson 104 St. James

18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
416 X	IMMEDIATE CAUSE	(A) Massive Cerebral Embolism	Instantly
	ANTECEDENT CAUSE(S) DUE TO	(B) Left ventricular thrombosis	2 years
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(C) Rheumatic Heart Disease	25 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-15 ..., 1953, to 10-23 ..., 1957, that I last saw the deceased alive on 9-26 ..., 1957, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

SIGNATURE James R. Grabill M.D. ADDRESS (Street, city, town, state) 1945 W. Balto. St. Balto 23, Md. DATE SIGNED 10-24-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10 28 57	Baltimore National	Baltimore, Md

24. RECD BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
OCT 25 1957	L. F. McAlley	George F. Schnabel	210 Frederick Ave

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely f... by the funeral director page ... should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with n 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10:57

CERTIFICATE OF DEATH

10175
Reg. Dist. No. 21

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. NAVAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
d. STREET ADDRESS: Box 366, Riverside Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Lonna — Middle: Charline — Last: DOWNEY
4 DATE OF DEATH: Month: October — Day: 31 — Year: 19 57

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6 March 1957
9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months 7 Days 25 — IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Jack Parker DOWNEY
14. MOTHER'S MAIDEN NAME: PATERCIA LEE THOMAS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: - - -
17. INFORMANT — Address: U.S. Naval Hospital, Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SEPTICEMIA with adrenal insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 20 Hours
501X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Tracheobronchitis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 31 October 1957 to 31 October 1957, that I last saw the deceased alive on 31 October 1957, and that death occurred at 2:35 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: Francesco De Paolo M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Annapolis, Md. — DATE SIGNED: 10-31-57
PHYSICIAN'S NAME (Type): Francesco De PAOLO — LT, Medical Corps, U.S. Naval Reserve

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 4, 1957
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Hopping Funeral Home Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: NOV 5 1957
24b. REGISTRAR'S SIGNATURE: Wm. J. French

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 10206

CERTIFICATE OF DEATH

Reg Dist No 27 — 10177

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
d. STREET ADDRESS: Hq 69th Sig Company
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: [illegible] — Middle: C. — Last: [illegible]

4. DATE OF DEATH: Month: Oct — Day: 16 — Year: 19 57

5. SEX: [illegible]

6. COLOR OR RACE: [illegible]

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 20 [illegible]overber 1920

9. AGE (In years last birthday): 36 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army

11. BIRTHPLACE (State or foreign country): Butler, Alabama

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown (Deceased)

14. MOTHER'S MAIDEN NAME: Unknown (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes

16. SOCIAL SECURITY NO: 285-12-0479

17. INFORMANT — Address: Personnel Records, Fort George G. Meade, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH:

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Hypertension, malignant — 15 yrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 0215 16 Oct 19 57 to 0315 16 Oct 19 57 that I last saw the deceased alive on 13 Oct, 1957, and that death occurred at 0315 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel D. Ogby, MD — ADDRESS (Street, city or town, state): USAH, Fort G. G. Meade, Md. — DATE SIGNED: 16 Oct 57

PHYSICIAN'S NAME (Type): SAMUEL D. [illegible], M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL — 22b. DATE THEREOF: 10/18/57 — 22c. NAME OF CEMETERY OR CREMATORY: J W Ross — 22d. LOCATION (City, town, or county) (State): 1155 - Main St, Warren, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: Earl B Wolverton Funeral Home, Inc — ADDRESS: 6306 - Belair Rd, Baltimore 6, Md.

24a. REC'D BY REGISTRAR — DATE: 16 Oct 57 — 24b. REGISTRAR'S SIGNATURE: Wilbur H. Downs, Jr. Capt. MSC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10178

10207

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: A. A. Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sudley
c. LENGTH OF STAY IN 1b: 60 yrs
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: A.A.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sudley
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Frances — Last: Duvall
4. DATE OF DEATH: Month: Oct — Day: 9 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 19 1894
9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West River
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph H Smith
14. MOTHER'S MAIDEN NAME: Georgianne Hanmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Chesley Duvall — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): myocardial failure — INTERVAL BETWEEN ONSET AND DEATH:
(60 X)
DUE TO (b): Diabetes mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): C. V. A.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. / Month / Day / Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 19 57 to Oct 9, 19 57, that I last saw the deceased alive on Oct 9, 19 57, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D. — ADDRESS (Street, city or town, state): Lothian, Md — DATE SIGNED: 10 12 57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 13 1957
22c. NAME OF CEMETERY OR CREMATORY: Mt Zion
22d. LOCATION (City, town, or county) (State): Lothian Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bernard O'Hardesty Hyattsville Md
24a. REC'D BY REGISTRAR DATE: 10/7/57
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

10208 Item 1, Film G222, 11/1/7 fwd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10179

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: ANN ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLENBURNIE, R.F.D. #2, Box 326
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Plaza Manor Nursing Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE, MD
d. STREET ADDRESS: 1913 DENTALOU ST.

3. NAME OF DECEASED (Type or print): First VICTORIA Middle DYSON Last
4. DATE OF DEATH: Month OCT. Day 23rd Year 19 57

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/21/1885
9. AGE (In years last birthday) 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (State or foreign country): HOWARD COUNTY, MD
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: EMANUEL WATKINS
14. MOTHER'S MAIDEN NAME: MARY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.:
17. INFORMANT: MARY V. PARKER — Address: 1913 DENTALOU ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 8 Yrs.
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c)
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 20 19 57, to October 23 19 57, that I last saw the deceased alive on October 20, 19 57, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Parr M.D. — ADDRESS (Street, city or town, state): 400 N. Carrollton Av — DATE SIGNED: October 24 1957
PHYSICIAN'S NAME (Type): DR. JAMES M. PARR — 400 N. CARROLLTON AV

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/25/57
22c. NAME OF CEMETERY OR CREMATORY: Mt Auburn
22d. LOCATION (City or town) (County) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Charles H. Arps — ADDRESS: 512 Cathedral
24a. REC'D BY REGISTRAR DATE: 10/28/57
24b. REGISTRAR'S SIGNATURE: L. V. Bradley

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10209

CERTIFICATE OF DEATH

10180

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lake Shore
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mountain Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lake Shore
d. STREET ADDRESS: Mountain Rd. - Box 383
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: BURT — Last: EBAUGH
4. DATE OF DEATH: Month: Oct. — Day: 13, — Year: 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 11,1884
9. AGE (In years last b'rthday): 73 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist (rtd)
10b. KIND OF BUSINESS OR INDUSTRY: Steel Mfg.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 212-07-5207
17. INFORMANT — Address: Mrs. Martha C. Ebaugh - Mountain Rd., Lake Shore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardio-hypetensive vascular diseases — INTERVAL BETWEEN ONSET AND DEATH: 4 yeears
DUE TO
Conditions, if any which gave rise to immediate cause (a) stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 1954 19____ to October 13th/19 57 that I last saw the deceased alive on 10/13/57 19____, and that death occurred at 4 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — ADDRESS (Street, city or town, state): 5 Fountain St. Frederick Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/16/57
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
22d. LOCATION (City or town or county) (State): Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: WM. J. TICKNER & SONS - Balto. 17, Md.
24a. REC'D BY REGISTRAR DATE: OCT 17 1957
24b. REGISTRAR'S SIGNATURE: J. J. Adkins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10181

10210

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 26ys,3mo,20ds
d. NAME OF HOSPITAL OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mississippi — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Holka
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Arthur — Middle — Last: Elliot

4. DATE OF DEATH: Month: 10 — Day: 21 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1885

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Elliott

14. MOTHER'S MAIDEN NAME: Sallie Steen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Congestive Heart Failure
DUE TO
(c): Generalized Arteriosclerosis

J50.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paranoid Condition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: ——— 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/1, 19 31 to 10/21, 19 57 that I last saw the deceased alive on 10/21, 19 57, and that death occurred at 12:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L Benedict M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 10/21/57

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL—CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 10.22.'57
22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med School
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible] Reese St

24a. REC'D BY REGISTRAR DATE: 10/23/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

-MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10182

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3 Monticello Ave

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 3 Monticello Ave
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle WIGGINS Last FORD
4. DATE OF DEATH: Month Oct Day 30 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 13th 1904
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer
10b. KIND OF BUSINESS OR INDUSTRY: News Paper
11. BIRTHPLACE (State or foreign country): Lancaster Pa
12. CITIZEN OF WHAT COUNTRY? U. S A

13. FATHER'S NAME: David L. Ford
14. MOTHER'S MAIDEN NAME: May L. Wiggins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John D. Ford Address: 1057 13 Hixton Rd Front Royal Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Thrown From Automobile — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a m p m, Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-2-57
EXAMINER'S NAME (Type): E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 11-2-57
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Linglestown Pa

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Hayden Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: 11/4/57
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Five pages 1 and 2 with the registrar's signature prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

.10211 Items 8,9: G221 10-22-57L

10183 Reg. Dist. No.

1

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician

VS A15 (4) 15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo, X.
d. STREET ADDRESS: Oldge Farm
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First Carl — Middle Andreas — Last Forslund

4. DATE OF DEATH: Month Oct. — Day 7, — Year 1957

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-19-1912

9. AGE (In years last birthday): 45 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: TRUCK

11. BIRTHPLACE (State or foreign country): Sweden

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Andreas Forslund.

14. MOTHER'S MAIDEN NAME: Helena Granbsted

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. C. A. Forslund — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 7, 1957, to 12:10 AM, 19—, that I last saw the deceased alive on Oct 7, 1957, and that death occurred at 12:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M. Lim M.D. — ADDRESS (Street, city or town, state): RFD #1 Box 277-M — DATE SIGNED: Oct. 7, 1957

PHYSICIAN'S NAME (Type): Sylvia M. Lim, — Edgewater, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-9-57

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest

22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 10/8/57

24b. REGISTRAR'S SIGNATURE: U. Linnard

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10184

10212 **CERTIFICATE OF DEATH**

Reg. Dist. No. 24

1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie
d. STREET ADDRESS Lee Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: William Middle: Alfred Last: Fredericks

4. DATE OF DEATH Month: Oct. Day: 26, Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 7, 1886

9. AGE (Last birthday) 71 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Post Office

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Fredericks

14. MOTHER'S MAIDEN NAME: Henrietta Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mrs. Violette E. James 1340 N. Carey Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ? yrs.

422.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 1, 1957, to October 25 1957, that I last saw the deceased alive on October 23, 19 57, and that death occurred at 10:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE James M. Pair M.D. ADDRESS (Street, city or town, state): 400 N. Carrollton Avenue DATE SIGNED: 10.29.57

PHYSICIAN'S NAME (Type): James M. Pair, M.D. Baltimore 23, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 29, 1957

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Holland Funeral Home 1631 Druid Hill Ave.

24a. REC'D BY REGISTRAR DATE: 10/30/57

24b. REGISTRAR'S SIGNATURE: L. J. Hobbs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed in by the funeral director page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10185

10213

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.

c. LENGTH OF STAY IN 1b: 6 ys.2 mos.19c.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Md.

d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Crownsville State Hospital, Md.

d. STREET ADDRESS: West Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry Middle: Jackson Last: Furness

4 DATE OF DEATH: Month: 10 Day: 2 Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 9/23/1896

9 AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY: ---------

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: George W. Furness

14. MOTHER'S MAIDEN NAME: Nellie Bly

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W. W. I

16. SOCIAL SECURITY NO: 219-07-6035

17 INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 9/30/57

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) DUE TO: Supporative Peritonitis

(c) DUE TO: Chronic Ulcerative Colitis with perforation

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with Arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year ——— 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 7/13 19 51, to 10/2 19 57, that I last saw the deceased alive on 10/2 1957, and that death occurred at 2:45 P M, from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 10/2/57

PHYSICIAN'S NAME (Type): L. Benedict, M. D. Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/5/57

22c. NAME OF CEMETERY OR CREMATORY: Mem. Park Inc.

22d LOCATION (City, town, or county): Salisbury (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor E. Street ADDRESS: Salisbury Md

24a REC'D BY REGISTRAR DATE: OCT 9 1957

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10159

CERTIFICATE OF DEATH

10186

Reg Dist. No.

1 PLACE OF DEATH a. COUNTY A.A. Co. MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION A.A. General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE Maryland b COUNTY A.A. Co.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.
d. STREET ADDRESS 1 Cheston St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Hamilton Middle Adams Last Gale
4 DATE OF DEATH Month 10 Day 2 Year 1957

5. SEX M
6. COLOR OR RACE W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-12-1908
9 AGE (In years last birthday) 49 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10b. KIND OF BUSINESS OR INDUSTRY Air Conditioning
11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Hamilton A. Gale
14 MOTHER'S MAIDEN NAME Alice Loomis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT Lucy D. Gale Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 2 wk

DUE TO (b) Kennmel-Stiel-Wilson Disease — 3 yr.

DUE TO (c) Diabetes M. — 2 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 4- -, 19 57 to 10-2-, 19 57 that I last saw the deceased alive on 10-2-57, 19 , and that death occurred at 8 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Frank M. Shipley M.D. ADDRESS (Street, city or town, state) 63 College Ave Annapolis DATE SIGNED

PHYSICIAN'S NAME (Type) Frank M. Shipley 10-4-57

22a BURIAL CREMATION REMOVAL (Specify) Burial
22b DATE THEREOF 10-5-1957
22c. NAME OF CEMETERY OR CREMATORY St. Anne's
22d LOCATION (City, town or county) Annapolis (State) Md.

23 FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE 10/4/57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10214

CERTIFICATE OF DEATH

Reg. Dist. No. 10187

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Maryland — b COUNTY: Baltimore City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.

c. LENGTH OF STAY IN 1b: 4ys.2mos.22d.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

d STREET ADDRESS: 1820 E. Fayette St.

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Walter — Middle Anderson Lee Newson — Last German

4 DATE OF DEATH: Month 10 — Day 9 — Year 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/6/38

9. AGE (In years on last birthday): 18 yrs.

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ———

11 BIRTHPLACE (State or foreign country): ——— Md.

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Walter Rock

14 MOTHER'S MAIDEN NAME: Pauline Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ———
(If yes, give war or dates of service): ———

16 SOCIAL SECURITY NO: ———

17 INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia confluent

4-71X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with Convulsive Disorders with Behavior Reactions

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o'clock a. m. p. m. — Month, Day, Year ——— 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 7/17/53, 19—, to October 9, 1957, that I last saw the deceased alive on October 9, 1957, and that death occurred at 8:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED: 10/12/57

NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-15-57

22c. NAME OF CEMETERY OR CREMATORY: MOUNT CALVARY CEM

22d. LOCATION (City, town, or county) (State): ARUNDEL Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Sarah L. Brown & Son — ADDRESS: 108 W. MONTGOMERY ST, BALTO Md.

24a. REC'D BY REGISTRAR DATE: 10/18/57

24b. REGISTRAR'S SIGNATURE: [signature]

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10161 **CERTIFICATE OF DEATH** Reg. Dist. No. 10189

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION A.A. GENERAL Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS
e. STREET ADDRESS 1 SHIPWRIGHT HARBOR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First HAZEL Middle Voit Last GILLMER
4 DATE OF DEATH Month 10 Day 17 Year 1957
5 SEX F
6. COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 11-5-1885
9 AGE (In years last birthday) 71 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (State or foreign country) OHIO
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME CHARLES Voit
14 MOTHER'S MAIDEN NAME HELEN WONDERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17 INFORMANT Address THOMAS C. GILLMER #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 wk.

430.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Hypertensive Arteriosclerotic Heart Disease — 1 yr.

DUE TO (c) Arteriosclerosis Generalized — 1 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1, 1954 to Oct. 17, 1957, that I last saw the deceased alive on Oct. 17, 1957, and that death occurred at ____ M, from the causes and on the date stated above

ACTUAL SIGNATURE James R. Martin M.D. ADDRESS (Street, city or town, state) 6 SHAW ST. ANNAPOLIS, MD. DATE SIGNED 10/18/57
PHYSICIAN'S NAME (Type) JAMES R. MARTIN

22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 10-21-57
22c. NAME OF CEMETERY OR CREMATORY OAK WOOD
22d LOCATION (City, town or county) (State) WARREN OHIO

23 FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE 10/18/57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10215

CERTIFICATE OF DEATH

10190 78
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 1yr,9mo,22ds
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro 16
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Luell; Middle; Last Gross
4. DATE OF DEATH: Month 10; Day 28; Year 1957
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/2/1886
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13. FATHER'S NAME: George Gross
14. MOTHER'S MAIDEN NAME: Mattie Thomason
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO: ———
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Arteriosclerotic Cardio-vascular Disease

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Epilepsy

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. ——— 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/6, 1956, to 10/28, 1957, that I last saw the deceased alive on 10/28, 1957, and that death occurred at 8:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Conwell Newton M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 10/29/57

PHYSICIAN'S NAME (Type): Conwell Newton, M. D. — Crownsville State Hospital, M.d

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 11-1-57
22c. NAME OF CEMETERY OR CREMATORY: St. Luke Methodist
22d. LOCATION (City, town, or county) (State): Upper Marlboro Md

23. FUNERAL DIRECTOR'S SIGNATURE: Henry S. Washington & Sons
ADDRESS: 467 N St N.W.
24a. RECD BY REGISTRAR
DATE: 11/1/57
24b. REGISTRAR'S SIGNATURE: T. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WS A15 (4)
15M 9/55

10216

11437
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian
LENGTH OF STAY (In this place) Life?
HOSPITAL OR INSTITUTION OR STREET ADDRESS None

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Lothian
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Richard (Middle) (Last) Gross

4. DATE OF DEATH (Month) 10 (Day) 28 (Year) 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)

8. DATE OF BIRTH. 4/12/73

9. AGE Last birthday: 84 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Tobacco

11 BIRTHPLACE (State or foreign country) Tracys Landing Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WILLIAM GROSS

14. MOTHER'S MAIDEN NAME: Catherine Neale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Eva Gross, Lothian Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
Immediate cause	(a) DUE TO	Coronary Occlusion	Immediate
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	Cardiac decompensation	2+ years
	(c)	Arteriosclerosis	2+ years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Overexertion

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE J. D. Kendrick M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM ☒

DATE SIGNED 10-30-57

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Oct 31 1957

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State) Lothian Md

DATE RECEIVED BY LOCAL REG 11/2/57

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR Russell Hardesty

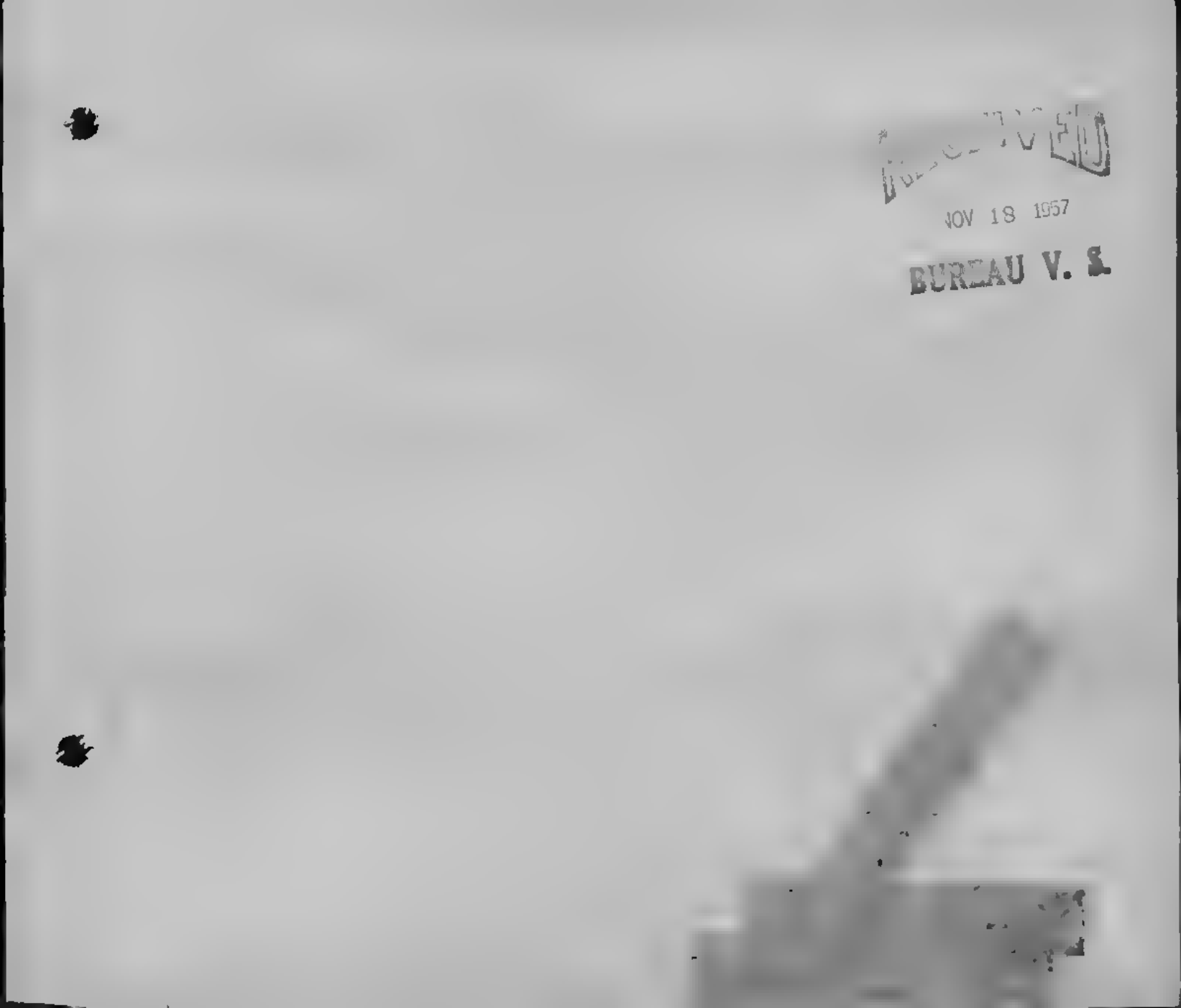
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5-53

Nov 9 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10217

CERTIFICATE OF DEATH

10191

Reg. Dist. No. 27

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland — b COUNTY: Anne Arundel

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Fort George G. Meade

c. LENGTH OF STAY IN 1b: 1 da 8hr 55min

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: U. S. Army Hospital

d STREET ADDRESS: Box 75A

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DEBBRA — Middle: LYNN — Last: GUNTER

4. DATE OF DEATH: Month: October — Day: 3 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1 October 1957

9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS: Hours: 8 — Min.: 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clarence Gunter, Jr.

14. MOTHER'S MAIDEN NAME: Ursula Ida Lobe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Father, Box 75A, Severn, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Prematurity Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1da 8hr 55min

776x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Oct, 19 57, to 3 Oct, 19 57, that I last saw the deceased alive on 30 Sept 3 Oct 19 57 57 and that death occurred at 0840 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Frank L. Gruskay, M.D. — ADDRESS (Street, city or town, state): USAH, Ft G. G. Meade, Maryland — DATE SIGNED: 3 Oct 57

PHYSICIAN'S NAME (Type): FRANK L. GRUSKAY, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct-4-1957

22c. NAME OF CEMETERY OR CREMATORY: Baltimore Maryland

22d. LOCATION (City, town, or county) (State): Frederick Road Md

23. FUNERAL DIRECTOR'S SIGNATURE: Earl B. Winters Funeral Home Inc — ADDRESS: 6306 Belair Rd Balto-6 Md

24c. REC'D BY REGISTRAR — DATE: 3 Oct 57

24d. REGISTRAR'S SIGNATURE: Wilbur H. Downs, Jr. Capt. MSC

50204 XVC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10218 — 10192 — Reg. Dist. No. 21

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Annapolis
c. LENGTH OF STAY IN 1b: 16 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mulberry Hill Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Res. before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Annapolis
d. STREET ADDRESS: Mulberry Hill R.F.D. 4 Annapolis Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lydia — Middle: R. — Last: Ganther
4. DATE OF DEATH: Month: 10 — Day: 3 — Year: 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 19, 1871
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Grebe
14. MOTHER'S MAIDEN NAME: Katherine Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Herman Ganther — Address: R.F.D. 4 Annapolis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Lida Hardt, M.D.
EXAMINER'S NAME (Type): E. Lida Hardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/3/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-7-57
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George L. Schaal — ADDRESS: 2101 Pennsylvania Ave, Baltimore Md.
24a. REC'D BY REGISTRAR: OCT 7 1957
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the record of burial or cremation.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10162 CERTIFICATE OF DEATH

Reg. Dist No. 10193

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

c LENGTH OF STAY IN 1b

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 535 Horn Point Drive

d. STREET ADDRESS: 635 Horn Point Drive

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Le Roy Middle: Last: Habersank

4 DATE OF DEATH: Month: October Day: 17 Year: 1957

5. SEX: Mak

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-23-1895

9 AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clothing Cutter

10b. KIND OF BUSINESS OR INDUSTRY: Tailoring

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Charles Habersank

14. MOTHER'S MAIDEN NAME: Kate High

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO

17 INFORMANT: Eva Habersank Address: ~~#~~ 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1956, 19___, to oct 17, 1957, that I last saw the deceased alive on oct 17, 1957, and that death occurred at 10:2 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Linhardt M.D. ADDRESS (Street, city or town, state): Annapolis Maryland DATE SIGNED

PHYSICIAN'S NAME (Type): E. Linhardt

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-19-57

22c. NAME OF CEMETERY OR CREMATORY: Wood Lawn

22d LOCATION (City or town, or county) (State): Baltimore Md.

23 FUNERAL DIRECTOR'S SIGNATURE: John H. Taylor & Son ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 10/18/57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10219 **CERTIFICATE OF DEATH** Reg. Dist. No. 10194-8

1 PLACE OF DEATH a. COUNTY A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glambrills
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glambrills, Md
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First Thomas Middle Last Fuller
4 DATE OF DEATH Month Oct Day 1 Year 1957

5 SEX Male
6 COLOR OR RACE Colored
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH Jun 12 1877
9 AGE (In years last birthday) 80 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Hod Bas. Made
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis Md
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME George Hall
14. MOTHER'S MAIDEN NAME Hurd (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 216-18-5077
17 INFORMANT Mrs Francis Hall Address 553 Gold St Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Thrombosis
4 A.M.
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/27/57 19____ to 9/30/57 19____, that I last saw the deceased alive on 9/30/57 19____, and that death occurred at 1:15 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE John C Alexander M.D. ADDRESS (Street, city or town, state) Glen Burnie DATE SIGNED 10/4/57
PHYSICIAN'S NAME (Type) JOHN C. ALEXANDER

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b DATE THEREOF Oct 7 1957
22c. NAME OF CEMETERY OR CREMATORY Macedonia
22d. LOCATION (City, town, or county) Glambrills (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE J. B. Johnson ADDRESS Annapolis
24a. RECD BY REGISTRAR DATE OCT 8 1957
24b REGISTRAR'S SIGNATURE T. M. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death

VS A15 (4) 15M 9/55

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit; file pages 1 and 2 with the Board of Health, designated agent prior to burial cremation or removal and in any event within 72 hours after death

VS ATSME 8M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10195

Reg Dist No 21

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Baltimore 25
c LENGTH OF STAY IN: Over 3 years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 5743 Bellegrove Rd,

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a STATE: Same — b COUNTY: Same
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Same
d STREET ADDRESS: Same
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: Sarah — Middle: Mathilda — Last: Hines

4 DATE OF DEATH: Month: Oct. — Day: 13th, — Year: 1957 — 19

5 SEX: F

6 COLOR OR RACE: C

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 1/27/87

9 AGE (In years last Birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): A.A.County,Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Benjamin Snowden

14 MOTHER'S MAIDEN NAME: Sarah Queen

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: No

16 SOCIAL SECURITY NO:

17 INFORMANT: Mrs. Mary A. Gibson (daughter) — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Occlusion

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour ____ a. m. p. m. — Month, Day ____ Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert M.D — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — 10/13/57

22a BURIAL CREMATION REMOVAL (Specify): Burial
22b DATE THEREOF: October 16, 1957
22c NAME OF CEMETERY OR CREMATORY: Mount Calvary Cemetery
22d LOCATION (City, town, or county) (State): Brookland; A.A. Co. Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Elroy A Wilson — ADDRESS: 1000 Brantley Lane

24a RECD BY REGISTRAR DATE: OCT 15 1957

24b REGISTRAR'S SIGNATURE: Ida Hutson

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10163

CERTIFICATE OF DEATH

10197

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Serena Park
d. STREET ADDRESS: Rt 1 Box 104A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gail — Middle: (n) — Last: Hume

4. DATE OF DEATH: Month: October — Day: 20 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-19-1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: — Days: 7 — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? United Kingdom

13. FATHER'S NAME: Peter D. Hume

14. MOTHER'S MAIDEN NAME: Dorothy Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Peter D. Hume — Address: # 7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

116 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 Oct 1957 to 20 Oct 1957 that I last saw the deceased alive on 20 Oct 1957, and that death occurred at 7:10 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Carroll Bldg, Annapolis

DATE SIGNED: 23 Oct 57

PHYSICIAN'S NAME (Type): Stuart H. Mitchell M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-23-57

22c. NAME OF CEMETERY OR CREMATORY: Private Cemetery

22d. LOCATION (City, town or county) (State): Near Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Taylor & Son

ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 10/25/57

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the register prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10221 **CERTIFICATE OF DEATH** 10198

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

YS A15 (4) 15M 9/55

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1814 Druid Hill Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Fred — Middle Lee — Last Hunter
4. DATE OF DEATH: Month 10 — Day 26 — Year 19 57

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 3/3/21
9. AGE (In years last birthday): 36 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Worker in Shipyard
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: John Hunter
14. MOTHER'S MAIDEN NAME: Maggie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO: ----------
17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

490X

DUE TO (b): Pulmonary gangrene

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Lobar Pneumonia — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Alcoholism with Delirium Tremens

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ----------
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: ----- 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------
20f. (City or town) (County) (State): ----------

21. I certify that I attended the deceased from 10/24 19 57 to 10/26 19 57, that I last saw the deceased alive on 10/26 19 57, and that death occurred at 8:10 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 10/28/57

PHYSICIAN'S NAME (Type): Ludwig Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10-31-57
22c. NAME OF CEMETERY OR CREMATORY: BALTO-NATIONAL
22d. LOCATION (City, town, or county) (State): BALTIMORE Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: WILLIAM A. JACKSON INC.
24a. REC'D BY REGISTRAR — DATE: 11-1-57
24b. REGISTRAR'S SIGNATURE: Catherine Joyce

THIS IS A PERMANENT RECORD
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg
HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTE

10199

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print): Andrew J Jacob

2. DATE OF DEATH: Oct. 25 1957

3. PLACE OF DEATH: A Baltimore City, Maryland Arundel County

B FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ridge Rd. Hanover Md.

C Length of stay in Baltimore: Yrs. Mos. Days: Lifetime

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A STATE: Maryland B COUNTY: Anne Arundel County

C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hanover

D STREET ADDRESS (If rural, give location): Ridge Rd Hanover Md.

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2/6/12

9. AGE (In years last birthday): 45 If Under 1 Year: Months Days If Under 24 Hours: Hours, Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Keeper

10B KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Jacob

14. MOTHER'S MAIDEN NAME: Eva Madler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Jacobs ADDRESS: Ridge Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 8/2/57

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B CONDITION FOR WHICH OPERATION WAS PERFORMED

20 AUTOPSY? YES ☐ NO ☒

21D TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22 I certify that (I) (this hospital) attended the deceased from 8/2 1957 to 10/25 1957, that (I) (we) last saw the deceased alive on 10/25 1957, and that death occurred at 11:15 P.M., from the causes and on the date stated above.

23A SIGNATURE: Elizabeth Snyder M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

23B. ADDRESS: Medical Arts Building

23C. DATE SIGNED: 10/28/57

24A BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct. 29 1957

24C NAME OF CEMETERY OR CREMATORY: Whitiss Cem.

24D LOCATION (City, town, or county) (State): Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: 10-28-57

REGISTRAR'S SIGNATURE: A. H. Hendricks

25 FUNERAL DIRECTOR: Charles J Dell

ADDRESS: 2016 Fork

1

FOR STATE HEALTH DEPT.

M

- MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

, 10223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10209

Reg Dist No. 1

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Earleigh Heights
c LENGTH OF STAY IN 1b: 3 hrs.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): In the front seat of a truck,

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE: Maryland — b COUNTY:
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Baltimore
d STREET ADDRESS: 935 Somerset St.
e SAME AS ON LEFT: YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First John — Middle — Last Jacobs
4 DATE OF DEATH: Month October — Day 12th — Year 1957

5 SEX: M
6 COLOR OR RACE: C
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 1/28/06
9 AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

M / W

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b KIND OF BUSINESS OR INDUSTRY: Baltimore Transit Co.
11 BIRTHPLACE (State or foreign country): Marion, S.C.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Willie Jacobs
14. MOTHER'S MAIDEN NAME: ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give war or dates of service): No
16 SOCIAL SECURITY NO:
17 INFORMANT (Address): Mrs. Eva Jacobs (wife)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
400.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day — Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒ Accident ☐, Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Leonard H. Faubert M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/12/57
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 10-16-57
22c NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem A. A. Co
22d LOCATION (City, town, or county): (State) Md
23 FUNERAL DIRECTOR'S SIGNATURE: Rayner Sanders
ADDRESS: 217 E. Preston St
24a RECEIVED BY REGISTRAR: DATE 10/15/57
24b REGISTRAR'S SIGNATURE: L. J. Dealley

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 will be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or as designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15ME
BM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10224 Reg. Dist No. 28

1. PLACE OF DEATH
a. COUNTY: B.C.Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Towson
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville - State - Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Balto.
d. STREET ADDRESS: 1608 W. Lafayette Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First James Middle Last Janey
4. DATE OF DEATH: Month 10 Day 5 Year 57
5. SEX: M.
6. COLOR OR RACE: C.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 16 1893
9. AGE (In years last birthday): 23 yrs. UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lapemen
10b. KIND OF BUSINESS OR INDUSTRY: Slaughter House
11. BIRTHPLACE (State or Foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John H. Janey
14. MOTHER'S MAIDEN NAME: Irene Bowie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Janey Address: 1608 W. Lafayette Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suicide — INTERVAL BETWEEN ONSET AND DEATH: Instan
DUE TO (b): Strangulation. (S)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Tied Sheet around neck & hung self
20c. TIME OF INJURY Hour a m Month 10 Day 5 Year 57 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Hospital
20f. (City or town): (County): BCo (State): MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. Finkhardt. DATE SIGNED: 10/8/57

22a. BURIAL CREMATION REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 9 1957
22c. NAME OF CEMETERY OR CREMATORY: Aloysius Memorial Park
22d. LOCATION (City, town or county) (State): Aloysius Memorial Park

23. FUNERAL DIRECTOR'S SIGNATURE: Mrs Katie R Williams ADDRESS: 322 Schroeder St.
24a. REC'D BY REGISTRAR DATE: OCT 9 58
24b. REGISTRAR'S SIGNATURE: H. M. Hynes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record of burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10164 **CERTIFICATE OF DEATH** Reg. Dist. No. 10202

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Norfolk
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norfolk (Merrimack Park)
d. STREET ADDRESS: 8819 Monitor Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First BABY Middle BOY Last JOHNSON

4 DATE OF DEATH: Month October Day 16 Year 1957

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: October 15, 1957

9 AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours 5 Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Robert Johnson

14 MOTHER'S MAIDEN NAME: Irene Kinley

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: none

17 INFORMANT Address: Mrs Irene Johnson- Mother- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Renal Disease (?)
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10-15-57 19___ to 10-16-57 19___, that I last saw the deceased alive on 10-16-57 19___, and that death occurred at 3:__ P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Allen M.D. ADDRESS (Street, city or town, state): 62 Cathedral St DATE SIGNED: 10-24-57

PHYSICIAN'S NAME (Type): A T ALLEN Annapolis, Md

22a BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: October 24, 1957

22c. NAME OF CEMETERY OR CREMATORY

22d LOCATION (City town or county) (State): Norfolk, Virginia

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOPPING FUNERAL HOME ANNAPOLIS, MARYLAND

24a. REC'D BY REGISTRAR DATE: OCT 23 1957

24b. REGISTRAR'S SIGNATURE: M. L. Hendry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10225 **CERTIFICATE OF DEATH** Reg. Dist. No. 10203 18

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN (b): 3ys,6mo.1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Craddock Nursing Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Daisy — Middle: King — Last: Johnson

4. DATE OF DEATH: Month: 10 — Day: 29 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Unknown

9 AGE (In years last birthday): 68? yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: ———

11 BIRTHPLACE (State or foreign country): Unknown

12 CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: George King

14. MOTHER'S MAIDEN NAME: Elizabeth

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ———
(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO: ———

17 INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Hypostatic Condition

DUE TO

(c): Carcinoma of cervix with Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with Arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): ———

20c. TIME OF INJURY: Month, Day, Year: Hour a. m. p. m. ——— 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from April 28, 1954 to October 29, 1957, that I last saw the deceased alive on October 29, 1957, and that death occurred at 6:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 10/30/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/1/57
22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School
22d. LOCATION (City, town or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE: 11/5/57
24b. REGISTRAR'S SIGNATURE: [illegible]

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record of death or prior to burial, cremation or removal

VS. A1SME(5)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A A General

2. USUAL RESIDENCE (Where deceased lived. If institution, Res. since before admission)
a. STATE: Md. b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1140 Eastport Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert Middle: P. Last: Johnston
4. DATE OF DEATH: Month: 10 Day: 22 Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-26-1888
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pump Station Opp.
10b. KIND OF BUSINESS OR INDUSTRY: City Annapolis
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Johnston
14. MOTHER'S MAIDEN NAME: Belle Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Margaret L Johnston (2) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Disease — Sudden
4343
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. Lin Padgett Annapolis Md
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/27/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-26-57
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemt
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: 10/28/57
24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10226 **CERTIFICATE OF DEATH** Reg. Dist. No. 10205 (1)

1 PLACE OF DEATH
a. COUNTY: A. A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater, Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Edgewater. Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater. Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Josiah — Middle: — Last: Jones
4. DATE OF DEATH: Month: 10 — Day: 9 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-1-1885
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: C. Knighton
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Amelia Hicks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Herbert Jones — Address: Edgewater. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic Hypertension — INTERVAL BETWEEN ONSET AND DEATH:
443x
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Cardio vascular disease Grade III — 3 Months
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 4, 1957 to October 9, 1957 that I last saw the deceased alive on October 9, 1957, and that death occurred at 1:10 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: R. E. Richardson M.D.
ADDRESS (Street, city or town, state): 110 CLAY STREET ANNAPOLIS, MD.
DATE SIGNED: 10/11/57
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-13-57
22c. NAME OF CEMETERY OR CREMATORY: Edgewood Memorial
22d. LOCATION (City, town, or county) (State): Davidsonville Md.
23. FUNERAL DIRECTOR'S SIGNATURE: William Reese
ADDRESS: 108 Washington Ave. Md.
24a. REC'D BY REGISTRAR DATE: 10/11/57
24b. REGISTRAR'S SIGNATURE: Wm. J. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10227

CERTIFICATE OF DEATH

Reg. Dist. No. 10206

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE — b COUNTY
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Laurel	c. LENGTH OF STAY IN 1b: 5 yrs.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Children's District Training School, Center, Laurel, Md.	d STREET ADDRESS: 517 - 16th Street, S.E. — e IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Karen — Middle Lee — Last Krivak	4 DATE OF DEATH: Month October — Day 6 — Year 1957
5 SEX: F	6 COLOR OR RACE: white
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH: 10/13/46
9. AGE (In years last birthday): 10 yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Washington, D.C.	12 CITIZEN OF WHAT COUNTRY? US
13 FATHER'S NAME: Louis Krivak	14 MOTHER'S MAIDEN NAME: Mildred Kulin Krivak
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) - (If yes, give war or dates of service) -	16. SOCIAL SECURITY NO: -
17 INFORMANT: District Training School, Laurel, Md. — Address: Children's Center	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) convulsive disorder

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour o m / p. m

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home farm factory street, office bldg. etc.)

20f (City or town) (County) (State)

21 **I certify** that I attended the deceased from August, 1956, to October, 1957, that I last saw the deceased alive on October 4, 1957, and that death occurred at 12:45 A.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Wilfred R. Ehrmantraut M.D. — ADDRESS (Street, city or town, state): Children's Center, Laurel, Md. — DATE SIGNED: 10/9/57

PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut, M.D. — Children's Center, Laurel, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 10/9/57	22c. NAME OF CEMETERY OR CREMATORY: D.T.S. School	22d. LOCATION City, town or county: Laurel, Md. (State)

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR DATE: 10/2/57 — 24b REGISTRAR'S SIGNATURE: Helen [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10166 **CERTIFICATE OF DEATH** 10207

Reg. Dist. No. 21

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

7 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: A. A. Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Arnold P.O.

d. STREET ADDRESS: Rt 2 Box 96

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First WILLIAM Middle H. Last LANGLEY

4 DATE OF DEATH: Month 10 Day 23 Year 1957

5 SEX: M

6. COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 8/27/07

9. AGE (In years last birthday): 50 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction, Camp George Meade

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Oil City, Penna

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elmer Langley

14. MOTHER'S MAIDEN NAME: Mary H.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16 SOCIAL SECURITY NO: 227-03-6341

17 INFORMANT: Mrs. Celine H. Langley, same — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:

(b) Arteriosclerotic C. V. Disease — 2 yrs +

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10/14/ 1957 to 10/23 1957, that I last saw the deceased alive on 10/23 1957, and that death occurred at 9:15 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Maurice F. Klawans M.D. ADDRESS (Street, city or town, state): Annapolis, Md. DATE SIGNED: 10/25/57

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS 31 Southgate Ave.

22a BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10, 25, 57

22c. NAME OF CEMETERY OR CREMATORY: Green Mount Cem.

22d LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Ruck — ADDRESS: 5305 Harford Road #14

24a. REC'D BY REGISTRAR DATE: OCT 28 1957

24b. REGISTRAR'S SIGNATURE: Thos. F. Hardy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with in 72 hours after death.

YS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10208

10167 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE Post Office
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAHLON Middle LOWMAN Last JR.

4. DATE OF DEATH: Month OCTOBER Day 18 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 7 1917

9. AGE (In years last birthday): 40 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grain Operator

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.

11. BIRTHPLACE (State or foreign country): Waterbury, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mahlon Lowman Sr.

14. MOTHER'S MAIDEN NAME: Rosa Lowman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: 212-12-4612

17. INFORMANT: Mrs. Emma Lowman - Wife- Address: Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/18/57, 19 52, to 10/18/57, 19 52, that I last saw the deceased alive on 10/18/57, 19 57, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John E. Hedeman, M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 10/19/57

PHYSICIAN'S NAME (Type): John Hedeman M.D. Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 22, 1957
22c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial Cemet.
22d. LOCATION (City, town, or county) (State): Millersville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME
ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: OCT 2 [illegible]
24b. REGISTRAR'S SIGNATURE: Wm. J. Hennessy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with [illegible] page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10168

CERTIFICATE OF DEATH

10209

Reg Dist No.

1. PLACE OF DEATH a. COUNTY: A A — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: A A
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General
d. STREET ADDRESS: 134 Murray Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: N. Last: Lyons
4. DATE OF DEATH: Month: 10 Day: 29 Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-4-1893
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William W. Russell
14. MOTHER'S MAIDEN NAME: Carrie Norfolk
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Douglas T Lyons — Address: 248 Main St Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Myocardial Infarction	4 hours
420.0 DUE TO (b)	Coronary Thrombosis	4 Hours
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Arteriosclerotic Heart Disease	10 Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PREVIOUS MYOCARDIAL INFARCTION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTR BUT NG ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1953 to 30 Oct 1957 that I last saw the deceased alive on 30 Oct 1957, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward F Bark M.D. ADDRESS (Street, city or town, state): 4 Seahorse Ave, Annapolis DATE SIGNED: 10/31/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-1-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: 11/1/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10169

CERTIFICATE OF DEATH

10210

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.N. Hospital, Annapolis, Maryland

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woolford — Rural
d. STREET ADDRESS: - - - - -
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: William — Middle: Alexander S. — Last: MACKLIN

4 DATE OF DEATH: Month: Oct — Day: 5 — Year: 1957

5 SEX: Male

6 COLOR OR RACE: Cau

7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8 DATE OF BIRTH: 23 July 1897

9 AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): J.S.Navy

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy

11 BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles F. MACKLIN

14 MOTHER'S MAIDEN NAME: Emily STEWART

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWI & WW II

16. SOCIAL SECURITY NO:

17 INFORMANT — Address: U.S.N. Hospital, Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CARCINOMA, STOMACH WITH METASTASIS — INTERVAL BETWEEN ONSET AND DEATH: One year

151X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21 I certify that I attended the deceased from 5 October, 1957, to 5 October, 1957, that I last saw the deceased alive on 5 October, 1957, and that death occurred at 9:20P M, from the causes and on the date stated above

ACTUAL SIGNATURE: Robert J Busse Jr M.D. — ADDRESS (Street, city or town, state): U.S.N. Hospital, Annapolis, Md. — DATE SIGNED: 10-6-57

PHYSICIAN'S NAME (Type): Robert J. BUSSE Jr. — LT MC USNR

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-8-1957

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l.

22d LOCATION (City, town, or county) (State): Arlington VA.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 10/8/57 — 24b. REGISTRAR'S SIGNATURE: U. Unruh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician on

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10228

10211

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate omitting the word "pending" in part I in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. The pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Ann Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn, Md
c. LENGTH OF STAY IN 1b: Few minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 170

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ft Meade Md — b. COUNTY: Ann Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Meade Md
d. STREET ADDRESS: 556th Ord Det Ft Meade Md
e. SAME AS ON 1a? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SP3 — Middle RA13539422 — Last MAKAVICKAS
4. DATE OF DEATH: October 9 1957
5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 20 Jul 1937
9. AGE (In years last birthday): 20 yrs
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier
10b. KIND OF BUSINESS OR INDUSTRY: ARMY
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Makavickas
14. MOTHER'S MAIDEN NAME: Dorothy Richards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Edward Makavickas, 621 5th Ave. McKeesport, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture of skull, fracture of mandible
DUE TO (b): and mutiple lacerations of face
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Automobile accident hit a post
20c. TIME OF INJURY: Hour a m 1130 p m — Month, Day 9 Oct — Year 57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 170 Severn Md
20f. (City or town) (County) (State): Ann Arundel County

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Raubenheimer M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 9 October 1957
NAME (Type): GUSTAVE H RAUBENHEIMER, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 14, 1957
22c. NAME OF CEMETERY OR CREMATORY: Versailles Cemetery
22d. LOCATION (City, town or county) (State): McKeesport, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J.F.Eline & Sons, Reisterstown, Md.
24a. REC'D BY REGISTRAR: DATE 10 Oct 57
24b. REGISTRAR'S SIGNATURE: Wilbur H. Downs, Jr. Capt. MSC

VS A15ME
SM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10229

CERTIFICATE OF DEATH

10212

Reg. Dist. No. 24

1 PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b [illegible]
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE [illegible]
b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn, Md.
d. STREET ADDRESS [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]

4 DATE OF DEATH Month [illegible] Day [illegible] Year 19[illegible]

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH [illegible]
9. AGE (In years last birthday) [illegible] yrs
IF UNDER 1 YEAR Months [illegible] Days [illegible]
IF UNDER 24 HRS Hours [illegible] Min [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ins. & R. Est. Broker
10b. KIND OF BUSINESS OR INDUSTRY Self Emp.
11. BIRTHPLACE (State or foreign country) [illegible] Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [illegible]
14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. [illegible]
17. INFORMANT [illegible] Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH [illegible]
4 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) [illegible]
DUE TO
(c) [illegible]

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1, 1957, to Oct. 11, 1957, that I last saw the deceased alive on Oct. 11, 1957, and that death occurred at 11.15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Francis I Codd M.D. ADDRESS (Street, city or town, state) [illegible] DATE SIGNED [illegible]

PHYSICIAN'S NAME (Type) Francis I. Codd M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 15/57
22c. NAME OF CEMETERY OR CREMATORY [illegible]
22d. LOCATION (City, town, or county) (State) [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS [illegible]
24a. RECD. BY REGISTRAR DATE OCT 16 1957
24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 2 should be detached for use as the burial-transit permit. Then page 3 should be removed carbon papers. Page 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10170

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10213

Reg Dist. No. 21

1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) City Dump.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland
b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 14 Johnson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Joseph Middle: Mason Last:
4. DATE OF DEATH Month: 10 Day: 12 Year: 1957

5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-15-1949
9. AGE (In years last birthday): 8 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Boy
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Waterbury Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Mason
14. MOTHER'S MAIDEN NAME: Bessie Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Mason Address: Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Injuries — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Metal Crate fell on Child while playing
20c. TIME OF INJURY Hour: Abt pm Month, Day, Year: 10-12 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) garage yard
20f. (City or town) Annapolis (County) Anne Arundel (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Linhardt M.D.
EXAMINER'S NAME (Type) E. LINHARDT.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 10-12-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF 10-15-57
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State): Waterbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Ryan ADDRESS: Anna. Md.
24a. REC'D BY REGISTRAR DATE 10/14/57
24b. REGISTRAR'S SIGNATURE: Wm J Lynch Jr

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [redacted] files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the record prior to burial, cremation, or removal

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10230

CERTIFICATE OF DEATH

10214

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Baltimore — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 100 East Hammond Ferry Road

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East Rural (Greenbank)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Bertha — Middle: P. — Last: McKinney

4 DATE OF DEATH: Month: 10 — Day: 18 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 28 1878
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaach Payne
14. MOTHER'S MAIDEN NAME: Mary A. Dewberry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: J.Evans McKinney — Address: Elkton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

4 4 0.1

DUE TO (b): Hypertension — 2 yrs +

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour: a. m. / p. m.; 19
20d. INJURY OCCURRED: White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 17, 1957, to Oct 18, 1957, that I last saw the deceased alive on Oct 18, 1957, and that death occurred at 4:45 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C Milton Linthicum M.D. — ADDRESS (Street, city or town, state): 106 W. Maple Rd. Linthicum Heights, Md — DATE SIGNED: 10/18/57

PHYSICIAN'S NAME (Type): C.Milton Linthicum

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-22-1957
22c. NAME OF CEMETERY OR CREMATORY: Bethel
22d. LOCATION (City, town, or county) (State): Chesapeake City, Cecil, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Hurst — ADDRESS: North East, Maryland
24a. REC'D BY REGISTRAR: DATE OCT 21 1957
24b. REGISTRAR'S SIGNATURE: Dr. Geo. M. Stuffle

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event with in 72 hours after death.

VS ATS (4)
15M 9/56

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial cremation or removal and in any event within 72 hours after death.

VS AIS (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10215

10171 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): U. S. General

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 15 Locust Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Jesse — Middle: Leech — Last: Medford

4 DATE OF DEATH: Month: 10 — Day: 7 — Year: 1957

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: December 17-1869

9 AGE (In years last birthday): 87 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk - U.S.N.A.

10b KIND OF BUSINESS OR INDUSTRY: Clerk Mid. Store

11 BIRTHPLACE (State or foreign country): Annapolis Md

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: Henry Medford

14 MOTHER'S MAIDEN NAME: Sarah Ann Lewis

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16 SOCIAL SECURITY NO: —

17 INFORMANT: Mrs William Clatanoff — Address: 1006 Beach St Annapolis Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

331x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): General arteriosclerosis — 4 yrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a m / p. m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 7, 1957, to Oct 7, 1957, that I last saw the deceased alive on October 7, 1957, and that death occurred at 10 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Maurice F Klawans M.D — ADDRESS (Street, city or town, state): 31 South Gay St Balto — DATE SIGNED: 10/8/57

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10-9-57 — 22c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemt — 22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 10/10/57 — 24b. REGISTRAR'S SIGNATURE: H. V. Wimsatt

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10172

CERTIFICATE OF DEATH

Reg. No. 10216

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.N. Hospital, Annapolis, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Severna Park
d. STREET ADDRESS: Route 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: Stanley — Middle: William — Last: MILLER

4. DATE OF DEATH: Month: Oct. — Day: 7 — Year: 1957

5 SEX: Male

6 COLOR OR RACE: Cau

7 MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 6 Oct 1957

9. AGE (In years last birthday): — yrs
IF UNDER 1 YEAR: Months — Days — Hours 9 — Min. 15
IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — — —

10b. KIND OF BUSINESS OR INDUSTRY: — — —

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Stanley MILLER

14. MOTHER'S MAIDEN NAME: Annelle Randleston SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — — —
(If yes, give war or dates of service): — — —

16. SOCIAL SECURITY NO: — — —

17 INFORMANT: U.S.N. Hospital, Annapolis, Maryland — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 3 Hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Cor triloculare and biventriculare — 9 Hrs.15 in

DUE TO

(c): Prematurity — 9 Hrs.15 Min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 October, 19 57, to 7 October, 19 57, that I last saw the deceased alive on 7 October, 1957, and that death occurred at 3:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. M. Kravitz, M.D. — ADDRESS (Street, city or town, state): U.S. Hosp. Annapolis, Md. — DATE SIGNED: 10-7-57

PHYSICIAN'S NAME (Type): H. M. KRAVITZ — LT. (MC) USNR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 10-8-1957 — 22c. NAME OF CEMETERY OR CREMATORY: U.S. NAVAL ACADEMY — 22d. LOCATION (City, town, or county): Annapolis — (State): Md.

23 FUNERAL DIRECTOR'S SIGNATURE: John W. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. RECD BY REGISTRAR DATE: 10/8/57 — 24b. REGISTRAR'S SIGNATURE: O. Brunck

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10231

CERTIFICATE OF DEATH

10217
Reg Dist. No.

1 PLACE OF DEATH
a COUNTY A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville
c. LENGTH OF STAY IN 16
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a STATE Md b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Kent Middle Barksdale Last Osborn
4 DATE OF DEATH Month Oct Day 18 Year 1957

5 SEX Male
6 COLOR OR RACE Colored
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH Jan 12 1908
9. AGE (In years last birthday) 49 yrs
IF UNDER 1 YEAR Months 9 Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) Sutherlin Va
12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME Henry Osborn
14. MOTHER'S MAIDEN NAME Charlotte Osborn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.
17 INFORMANT Charles Edmonds Address Davidsonville

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 10 Years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1, 1957 to Oct 18, 1957, that I last saw the deceased alive on Oct 17, 1957, and that death occurred at 11:55 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE Edward J. Merrill M.D. ADDRESS (Street, city or town, state) Lamberville DATE SIGNED 10-19-57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF Oct 21 1957
22c. NAME OF CEMETERY OR CREMATORY Osborne
22d. LOCATION (City, town or county) Sutherlin (State) Va

23. FUNERAL DIRECTOR'S SIGNATURE J.B. Johnson ADDRESS Annapolis Md
24a. REC'D BY REGISTRAR DATE OCT 22 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

10232

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 20-c, Film G-24-1, 10/58.cac

10218 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Near Pig Point
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address):

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: District of Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 518 Quincy Street, N.W.
RESIDENCE ON A FARM: YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES; Middle D.; Last PAYNE
4. DATE OF DEATH: Month October; Day 30; Year 19 57
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 30, 1920
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gov't. Electrician
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Gov't.
11. BIRTHPLACE (State or foreign country): Heathsville, Va.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: Daniel Payne
14. MOTHER'S MAIDEN NAME: Edwina Thompson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Dates, no, or unknown) (If yes, give war or dates of service): Yes 5/7/43-11/25/45
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Marion Payne — Address: 518 Quincy St., N. W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Drowning.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Fell out of boat.
20c. TIME OF INJURY: About 2:00 PM; Month Day Year: 10/26 57 10/19/57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Patuxent River
20f. (City or town): Pig Point (County): A.A. (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul F. Guerin M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 10/31/57
EXAMINER'S NAME (Type): Paul F. Guerin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-4-1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John T. Rhines & Co. 901 3rd St., S. W.
24a. REC'D BY REGISTRAR DATE: NOV 4 '57
24b. REGISTRAR'S SIGNATURE: Gilbert Church

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the next of kin. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMD. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AISME 5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10173

CERTIFICATE OF DEATH

10219
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: 7 A — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD — b. COUNTY: A A

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS

c. LENGTH OF STAY IN 1b: 1 day

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TRACys Landing Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL General

d. STREET ADDRESS: 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First VERA Middle [illegible] Last PEMBROKE

4. DATE OF DEATH: Month OCT Day 20 Year 1957

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

8. DATE OF BIRTH: Nov 10 1886

9. AGE (In years last birthday): 70 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hartsmakville W. VA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WINTON M. NIHISER

14. MOTHER'S MAIDEN NAME: Gustavid Weems Nihiser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO (b): Arteriosclerosis, generalized — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/20, 19 57 to 10/20, 19 57 that I last saw the deceased alive on 10/20, 19 57, and that death occurred at 5:05 P.M., from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED: 10/20/57

ACTUAL SIGNATURE: John L. Hedeman M.D.

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: OCT 22/57

22c. NAME OF CEMETERY OR CREMATORY: ST MARKS

22d. LOCATION (City, town, or county) (State): DEALE Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty Glenville Md.

ADDRESS

24a. REC'D BY REGISTRAR DATE: 10/24/57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10220

10233 CERTIFICATE OF DEATH Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1 PLACE OF DEATH:
COUNTY A. Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
MARYLAND LENGTH OF STAY (in this place) 74 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1412 Dated Rd.

2 USUAL RESIDENCE (HOME) OF DECEASED.
STATE Md. COUNTY A. Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN same
STREET ADDRESS (If rural give location) same

3 NAME OF DECEASED: (Type or Print) First: THOMAS (Middle) HARRY (Last) PENN

4. DATE OF DEATH: (Month) Oct (Day) 12 (Year) 1957

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 27 Feb 1883

9. AGE Last birthday 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Gen'l Passgr. Agt.

10b. KIND OF BUSINESS OR INDUSTRY: Steamship Co.

11 BIRTHPLACE (State or foreign country): Camp Chapel, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Penn (dec.)

14. MOTHER'S MAIDEN NAME: Eliz. Nichols (dec.)

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 215-07-5404

17. INFORMANT & ADDRESS: Mrs. Lillian Penn - Wife. 1412 Dated Rd Glen Burnie, Md.

18. MEDICAL CERTIFICATION

1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocarditis — Interval Between Onset And Death: 1 day

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Cerebral Vascular Accident — 10 days

DUE TO

(c) Hypertension — 10 yr.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis, generalized — 10 yr.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19 , to 12 Oct , 1957, that I last saw the deceased alive on , 19 , and that death occurred at 2:55 PM from the causes and on the date stated above.

SIGNATURE (Degree or title) H. F. Mangold M.D. ADDRESS 901 Edgely Rd. Glen Burnie DATE SIGNED 12 Oct 57

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 10/15/57

NAME OF CEMETERY OR CREMATORY Reisterstown Meth. Cem.

LOCATION (City, town, or county) (State) Reisterstown, Md.

DATE REC'D BY LOCAL REGISTRAR 10/14/57

REGISTRAR'S SIGNATURE L. Heath

24. FUNERAL DIRECTOR Wm. J. Tschudy & Sons

ADDRESS Bath St. Md

Note - Regular patient of Dr. Pritchards.

VS. A15

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 222 11-11-57 6

.10234

CERTIFICATE OF DEATH

10221 2 2

Reg Dist. No.

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Laurel, Md.
c LENGTH OF STAY IN (b): 14 years
d NAME OF HOSPITAL (If not in hospital give street address OR INSTITUTION): Children's District Training School Center, Laurel, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland — b COUNTY: Calvert
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake Beach P. O. (Randle Cliff)
d STREET ADDRESS: ---
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Roselle — Middle: Taylor — Last: Pickrel

4 DATE OF DEATH: Month: October — Day: 28 — Year: 1957

5. SEX	6. COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
F	white		March 6, 1936	21 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
--	--	Jersey City, N.J.	US

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Roselle Pickrel	Helen

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT (Address)
	--	Children's District Training School, Center, Laurel, Md.

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

491x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Mental Deficiency secondary to cerebral injury at birth

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a.m. p.m.	Month	Day	Year	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
			19					

21 **I certify** that I attended the deceased from August, 1956, to October, 1957, that I last saw the deceased alive on October 25, 1957, and that death occurred at 4:55 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Wilfred R. Ehrmantraut M.D. — ADDRESS (Street, city or town, state): Children's Center, Laurel, Md. — DATE SIGNED: 10/28

PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut, M.D. — Children's Center, Laurel, Md.

22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	10 31 57	[illegible]	[illegible]

23 FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible]

24a RECD BY REGISTRAR — DATE: 10/28/57 — 24b REGISTRAR'S SIGNATURE: Melvin Mearkle

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] by the funeral director page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10174

CERTIFICATE OF DEATH

10222

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U A General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 15 Cornhill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Dorsey — Last Rawlings

4. DATE OF DEATH: Month 10 — Day 19 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-6-1885
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman State
10b. KIND OF BUSINESS OR INDUSTRY: Watchman
11. BIRTHPLACE (State or foreign country): Annapolis Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William J. Rawlings
14. MOTHER'S MAIDEN NAME: Annie Schuble

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Catherine E. Fisher — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Hypostatic pneumonia	Few
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)	Emphysema	10 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1953 to 10/19 19 57 that I last saw the deceased alive on 10/19 1957, and that death occurred at 9:10 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. McGowan M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 10/20/57
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-22-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: Allen M. Taylor Sons
ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: 10/22/57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10235

CERTIFICATE OF DEATH

Reg. Dist. No. 10223

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: 7 yrs, 1 mo, 8ds.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 805 Rutland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: — Last: Rich
4. DATE OF DEATH: Month: 10 — Day: 20 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 63? yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Bracheson Rich
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ———
(If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO: ———
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: few days
470X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, Mixed Type
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ———
20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m. ——— 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): ———
20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from September 12 1950, to October 20 1957, that I last saw the deceased alive on October 20 1957, and that death occurred at 6:00 A M, from the causes and on the date stated above

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville, Md.
DATE SIGNED: 10/21/57

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/25/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
22d. LOCATION (City, town, or county): Balt. (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. O. Wilson
ADDRESS: 2004 Orleans St.
24a. REC'D BY REGISTRAR DATE: 10/29/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10224

10236

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Baltimore City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.

c. LENGTH OF STAY IN 1b: 4 ys, 2 mos, 25 ds.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

d. STREET ADDRESS: 1119 N. Caroline St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Josie — Middle: Ella — Last: Richardson

4. DATE OF DEATH: Month: 10 — Day: 8 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/12/1882

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Isam Hayler

14. MOTHER'S MAIDEN NAME: Anna H. Nuckles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): --- (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO: ---

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b): Generalized Arteriosclerosis — since admission 7/13/53
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year: --- 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from 7/13, 19 53, to 10/8, 19 57, that I last saw the deceased alive on 10/8, 19 57, and that death occurred at 2:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/12/57

22c. NAME OF CEMETERY OR CREMATORY: IRMA CEM.

22d. LOCATION (City, town or county) (State): IRMA S.C. — 10/8/57

23. FUNERAL DIRECTOR'S SIGNATURE: Randolph Bollick — ADDRESS: 1412 PRESTON ST

24a. REC'D BY REGISTRAR DATE: 10/14/57

24b. REGISTRAR'S SIGNATURE: M. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician on page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10175

CERTIFICATE OF DEATH

10225

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 36 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.N. Hospital, Annapolis, Maryland

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 107 Severn Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bert — Middle: John — Last: RINNESS

4. DATE OF DEATH: Month: October — Day: 6 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ W DOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9 Sep 1886

9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George RINNESS

14. MOTHER'S MAIDEN NAME: Julia BONNEWITZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): Yes — WWI & WWII

16. SOCIAL SECURITY NO: 213-22-0802

17. INFORMANT — Address: U.S.N. Hospital, Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hematoma, subdural left parietal region
DUE TO: cause spontaneous
(b):
DUE TO:
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Cerebral edema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month / Day / Year / Hour / a. m. p. m. / 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 October ... 19 57, to 6 October ... 19 57, that I last saw the deceased alive on 6 October ... 19 57, and that death occurred at 4:35 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. W. McRobert — M D

ADDRESS (Street, city or town, state): U.S.N. Hospital, Annapolis, Md.

DATE SIGNED: 7 Oct 1957

PHYSICIAN'S NAME (Type): J. W. MCROBERTS — LT MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-9-57

22c. NAME OF CEMETERY OR CREMATORY: Annapolis National

22d. LOCATION (City or town or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons

ADDRESS: Annapolis, Md.

24a. RECEIVED BY REGISTRAR DATE: 10/8/57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9 55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10237

CERTIFICATE OF DEATH

10226

Reg. Dist. No. 24

1 PLACE OF DEATH
a COUNTY Anne Arundel. Pasadena R.D. MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE Same — b. COUNTY

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Pasadena Md

c LENGTH OF STAY IN 1b
34 years.

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Near Pasadena. Md.

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
—

d STREET ADDRESS

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Rosetta Middle Madelin. Last Roberts.

4 DATE OF DEATH: Month October. Day 18 Year 1957

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Sept 24. 1880

9 AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At home.

10b. KIND OF BUSINESS OR INDUSTRY
At home

11 BIRTHPLACE (State or foreign country)
Baltimore. Md.

12. CITIZEN OF WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME
Richard Roberts.

14. MOTHER'S MAIDEN NAME
Laura Jane Matheney.

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)
No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO
no

17 INFORMANT
Mrs. Grace Van Metz - Address Pasadena. Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b) Cardio. Vascular Disease — 10 years

DUE TO (c) —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
None

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
—

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from 10 years, 19—, to —, 19—, that I last saw the deceased alive on Oct 17, 1957, and that death occurred at 5:40 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE James S. Billingsley M.D. ADDRESS (Street, city or town, state) 10 E Central Ave. Glen Burnie Md DATE SIGNED Oct 19, 1957

PHYSICIAN'S NAME (Type) James S. Billingsley M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: Oct. 21, 1957

22c. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.

22d. LOCATION (City, town, or county) (State): Balto. Md.

23 FUNERAL DIRECTOR'S SIGNATURE: R V Leighton ADDRESS: Glen Burnie, Md.

24a REC'D BY REGISTRAR DATE: OCT 23 1957

24b REGISTRAR'S SIGNATURE: L. J. LeMay

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death

YS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10227

10176

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 159 Prince George Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN — Middle A — Last RUSTEBERG

4. DATE OF DEATH: Month OCTOBER — Day 27 — Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 9, 1885

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W. Anderson

14. MOTHER'S MAIDEN NAME: Florence Blackburn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: 218-03-9204B

17. INFORMANT — Address: Mr Charles A. Rusteberg- Husband- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acut Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO (b): Arteriosclerot. & V.D. — —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes M. & Coma

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Feb, 1952 to 10-27-57 that I last saw the deceased alive on 10-27-57, 19____, and that death occurred at 1 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Frank M Shipley M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 10-28-57

PHYSICIAN'S NAME (Type): Frank Shipley — 63 College Ave Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 29, 1957

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

22d LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.

24a. DATE RECEIVED BY REGISTRAR: OCT 30 1957

24b. REGISTRAR'S SIGNATURE: Hon J Grundy

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10177 **CERTIFICATE OF DEATH** 10228

Reg. Dist. No. 21

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 96 Market Street

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
d. STREET ADDRESS: 96 Market Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3 NAME OF DECEASED (Type or print): First WILLIAM Middle H Last SANDERS

4 DATE OF DEATH: Month OCTOBER Day 8 Year 1957

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: May 5, 1867
9 AGE (In years last birthday): 90 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Sea Captian
10b KIND OF BUSINESS OR INDUSTRY: State of Maryland
11 BIRTHPLACE (State or foreign country): Annapolis, Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Daniel ~~Hunter~~ Sanders
14 MOTHER'S MAIDEN NAME: Mayy Heaver

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: None
17 INFORMANT: Family records — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardio Vascular Failure — INTERVAL BETWEEN ONSET AND DEATH: Several Days
DUE TO (b): Cancer of Rectum — Many Months
DUE TO (c): Senile Arteriosclerosis + Hypertension — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
154X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 6th, 1957 to Oct 8, 1957, that I last saw the deceased alive on 10-7-, 1957, and that death occurred at 6:30 M, from the causes and on the date stated above

ACTUAL SIGNATURE: J. Oliver Purvis M.D. — ADDRESS (Street, city or town, state): 40 Franklin St Annapolis Md — DATE SIGNED: 10/9/57

PHYSICIAN'S NAME (Type): J. Oliver Purvis MD — 40 Franklin Street, Annapolis, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Oct. 10, 57
22c NAME OF CEMETERY OR CREMATORY: St. Anne's Cemetery
22d LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a REC'D BY REGISTRAR DATE 10-11-57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10178 — 10229 — Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original or a copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 135 10M

1. PLACE OF DEATH

COUNTY: Anne Arundel — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gambrills

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print): Alfonus F. Sarner Sr.

4. DATE OF DEATH (Month) (Day) (Year): Oct. 2, 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min
Male	White	Married	May 6 1880	77 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cab. Painter (ret.)	Bethlehem Steel Co.	St. Marys Co. Md.	U.S.A.

13. FATHER'S NAME: Richard Sarner

14. MOTHER'S MAIDEN NAME: Nancy Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S ADDRESS
No	—	None	Mrs. Elizabeth Sarner - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2-4 wks.

ANTECEDENT CAUSE(S) DUE TO (B):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Influenza + Flu — 6 Days.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town, (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) A.M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-26-1957 to 10-2-1957, that I last saw the deceased alive on 10-2-1957, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

SIGNATURE: Frank M. Shipley M.D. — ADDRESS (Street, city, town, state): 63 Calley Ave, Annapolis — DATE SIGNED: 10-2-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 5 1957	Baldwin Memorial Gdns.	Millersville, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
OCT 8 1957	[illegible]	Willard F. Snyder	Glen Burnie, Md.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Sch 10238 Tzki

CERTIFICATE OF DEATH

10230 24
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: A. A.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lake Shore	c. LENGTH OF STAY IN 1b:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lake Shore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Lake Shore Drive	d. STREET ADDRESS: Lake Shore Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐	

3 NAME OF DECEASED (Type or print)	First: BERTHA	Middle:	Last: SCHRODETZKI	4 DATE OF DEATH	Month: Oct.	Day: 4,	Year: 19 57	
5 SEX: female	6 COLOR OR RACE: white	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH: 11/23/1856	9 AGE (In years last birthday): 100 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife	10b KIND OF BUSINESS OR INDUSTRY:	11 BIRTHPLACE (State or foreign country): Germany	12. CITIZEN OF WHAT COUNTRY?: U. S. A.					
13 FATHER'S NAME: ? Martin	14 MOTHER'S MAIDEN NAME: ?							
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO: no	17 INFORMANT: Mrs. Lillian Hammerbacher	Address: - Lake Shore, Md.					

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Arteriosclerotic cardio vascular disease — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town)	(County) (State)

21 I certify that I attended the deceased from October 1, 19 57 to October 4 19 57, that I last saw the deceased alive on October 3 19 57, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R M McLaughlin M D — ADDRESS (Street, city or town, state): RED 8 Box 442 Pasadena — DATE SIGNED: Oct 4 1957

PHYSICIAN'S NAME (Type):

22a BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 10/7/57	22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.	22d LOCATION (City, town, or county) (State): Baltimore, Md.	
23 FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tschudi & Son	ADDRESS: Baltimore, Md.	24a REC'D BY REGISTRAR (DATE): OCT 8 1957	24b REGISTRAR'S SIGNATURE: Fred A. Hays	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10239

CERTIFICATE OF DEATH

10231
Reg. Dist No.

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland b COUNTY: Anne Arundel

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patapsco Park

c LENGTH OF STAY IN 1b: 13 Years

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patapsco Park

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

d STREET ADDRESS: 317 Berlin Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ROBERT Middle L. Last SCOTT

4 DATE OF DEATH: Month October Day 23 Year 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: March 12, 1889

9 AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min —

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): South Caroline

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jim Scott

14 MOTHER'S MAIDEN NAME: Martha Y

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-4584

17. INFORMANT: Henrietta Scott Address: 317 Berlin Avenue

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 3 da.

DUE TO (b): Infectious arthritis, — 1 Mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 30 Sept, 1957 to 23 Oct 1957 that I last saw the deceased alive on 22 Oct 1957, and that death occurred at 4:00 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Reynold B. Lightston, M.D. ADDRESS (Street, city or town, state): 501 Cherry Hill Road, Baltimore 3, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): Reynold B. Lightston, Jr. M.D. Baltimore Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 10-26-57

22c NAME OF CEMETERY OR CREMATORY: Mt Calvary Inn

22d LOCATION (City, town, or county) (State): Brooklyn Md

23. FUNERAL DIRECTOR'S SIGNATURE: ELROY O. WILSON ADDRESS: 1000 Brantley Avenue

24a. REC'D BY REGISTRAR: OCT 29 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO BE SIGNED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10232

10240 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Maryland — b COUNTY: Baltimore City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.

c LENGTH OF STAY IN Ib: 1 yr, 4 mos, 19 ds.

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

d. STREET ADDRESS: 806 N. Fremont Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Saul — Middle: (Solomon) — Last: Scott

4 DATE OF DEATH: Month: October — Day: 1 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/12/83

9 AGE (In years last birthday): 74 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Odd Jobs

10b. KIND OF BUSINESS OR INDUSTRY: ———

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James Scott

14 MOTHER'S MAIDEN NAME: Anna Green

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO: ———

17 INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: about 10 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Prolonged Debility

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Convulsive Brain Syndrome. Generalized Arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ——— 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 5/11/56, 1956, to 10/1, 19 57, that I last saw the deceased alive on 10/1/57, 19——, and that death occurred at ——— M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Crownsville, Md.

DATE SIGNED: 10/2/57

PHYSICIAN'S NAME (Type): L. Benedict, M. D.

Crownsville State Hospital, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/4/57

22c. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park

22d LOCATION (City, town or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles R. Law — ADDRESS: 802-04 Madison Ave.

24a. REC'D BY REGISTRAR — DATE: OCT 8 195—

24b. REGISTRAR'S SIGNATURE ?

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10179

10233

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Emergency Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md.
b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Port
d. STREET ADDRESS 123 Bayshore Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First LEAH Middle B. Last SEARS

4 DATE OF DEATH Month October Day 28 Year 1957

5 SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 12, 1902
9 AGE (In years last birthday) 55 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11 BIRTHPLACE (State or foreign country) Md.
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Henry H. Schamel
14. MOTHER'S MAIDEN NAME Mary E. Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No —
16. SOCIAL SECURITY NO [redacted]
17 INFORMANT Address (Street) Walter F. Martin Humpstead, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 10 d.

DUE TO (b) Hypertension — 15 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10-15-57, 19____, to 10-28-57, 1957 that I last saw the deceased alive on 10-28-57 19____, and that death occurred at 1 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Frank M Shipley M.D. ADDRESS (Street, city or town, state) 63 College Ave Annapolis Md DATE SIGNED 10-12-57

PHYSICIAN'S NAME (Type) Frank M. Shipley Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-1-57
22c. NAME OF CEMETERY OR CREMATORY Linsley Freedom
22d LOCATION (City, town, or county) (State) Carroll Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE Luther H. Haight ADDRESS Sykesville, Md.
24a. RECD BY REGISTRAR DATE NOV
24b. REGISTRAR'S SIGNATURE Wm J. Tenney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 D

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10234

10241

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist No. 24

1 PLACE OF DEATH
a COUNTY Anne A undel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
c. LENGTH OF STAY IN 1b 6 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bay Side Beach

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE Same — b COUNTY Same
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) X Same
d STREET ADDRESS Same
e IS DECEASED EMPLOYED ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last: John Wilbur Seitz
4. DATE OF DEATH Month October Day 22 Year 19 57
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 12/22/07
9. AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Adam Seitz
14. MOTHER'S MAIDEN NAME: Margaret Virginia Walters
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Virginia Garlin, (Sister) Address: Pasadena, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour ... a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐; and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 10/22/57
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Oct 25, 1957
22c. NAME OF CEMETERY OR CREMATORY: Oak Lawn
22d LOCATION (City, town, or county) (State): Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lilly & Zeiler Inc., 403 S. Wolfe St.
24a REC'D BY REGISTRAR DATE 10/23/57
24b REGISTRAR'S SIGNATURE L. J. Medlow

TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. If any delay is necessary please explain in the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director for your Files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1SME SM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10242

CERTIFICATE OF DEATH

10235/54 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 2½ years

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same — Glen Burnie Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 704 Griffith Rd.

3. NAME OF DECEASED (Type or print): First Rita — Middle Anna — Last Senft

4. DATE OF DEATH: Month October — Day 16th. — Year 19 57

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/19/20

9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Baltimore, Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Grill

14 MOTHER'S MAIDEN NAME: Mary Blecha

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO: 219-01-6723

17 INFORMANT — Address: Mr. Walter J Senft (husband)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of the liver — INTERVAL BETWEEN ONSET AND DEATH: 2 months ?

I (a) I

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b):

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from August 19 57 to October 16, 19 57 that I last saw the deceased alive on October 15th. 19 57, and that death occurred at 12.35 A.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Gustave H Faubert M.D. — ADDRESS (Street, city or town, state): Glen Burnie, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 19-57

22c NAME OF CEMETERY OR CREMATORY: Holy Cross

22d LOCATION (City, town or county) (State): Brooklyn a Co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bernard G Finic, Glen Burnie Md

24a. REC'D BY REGISTRAR DATE: 10/21/57

24b. REGISTRAR'S SIGNATURE: L. J. DeWalt

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely [illegible] by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10236

10243

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1 PLACE OF DEATH
a. COUNTY: A.A.CO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BROOKLYN MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 303 AUDREY AVE

2 USUAL RESIDENCE Where deceased lived (If institution Residence before admission)
a. STATE: MD
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): BALTIMORE
d. STREET ADDRESS: 303 AUDREY AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First WILLIAM Middle F. Last SIMMONT

4 DATE OF DEATH: Month 10 Day 21 Year 1957

5 SEX: M

6. COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/25/1890

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SUP. MATTIESON CHEMICAL CO

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): BALTO MD

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HARRY T. SIMMONT

14 MOTHER'S MAIDEN NAME: MARY BOSMAN

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: ADDIE M. SIMMONT Address: 303 AUDREY AVE

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Heart disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Hypertension & Cardio Vascular Renal

DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 15, 1955 to Oct 21, 1957 that I last saw the deceased alive on 10/20, 1957 and that death occurred at 12:25 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Samuel Cohen M.D. ADDRESS (Street, city or town, state): 203 Catapsco ave DATE SIGNED

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/24/57

22c. NAME OF CEMETERY OR CREMATORY: SACRED HEART

22d. LOCATION (City, town, or county) (State): BALTIMORE MD

23. FUNERAL DIRECTOR'S SIGNATURE: Laurence F. Hoffman ADDRESS: 3218 Hudson St

24a. REC'D BY REGISTRAR DATE: OCT 23 1957

24b. REGISTRAR'S SIGNATURE: Ada Nelson

BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10244

CERTIFICATE OF DEATH

Reg. Dist. No. 10237

1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville Md
c. LENGTH OF STAY IN 1b June 21 1954
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sands Nursing Home

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md.
b. COUNTY AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
d. STREET ADDRESS Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Charles Middle H. Last Smith

4 DATE OF DEATH Month Oct Day 8 Year 1957

5. SEX M.

6. COLOR OR RACE White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Jan 10, 1873

9 AGE (In years last birthday) 84 yrs

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Mason

10b. KIND OF BUSINESS OR INDUSTRY Rail Road

11 BIRTHPLACE (State or foreign country) Baltimore Md

12 CITIZEN OF WHAT COUNTRY U.S.

13. FATHER'S NAME Augustus Smith

14. MOTHER'S MAIDEN NAME ?

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO Unknown

17 INFORMANT Address Son - Severna Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage

330 x

DUE TO (b) Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1955 19 57 to 1957 19 ____, that I last saw the deceased alive on 10-4-57 19 ____, and that death occurred at 2:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert B Hahn M.D.

ADDRESS (Street, city or town, state) Severna Park

DATE SIGNED 10-8-57

PHYSICIAN'S NAME (Type) Robert B. Hahn Severna Park Md.

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF Oct. 11 1957

22c. NAME OF CEMETERY OR CREMATORY Glen Haven

22d LOCATION (City, town, or county) Glen Burnie (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE R. Singleton

ADDRESS Glen Burnie, Md.

24a REC'D BY REGISTRAR DATE 10-10-57

24b REGISTRAR'S SIGNATURE Katherine Joyce Reg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10245

CERTIFICATE OF DEATH

10238

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Md.
c. LENGTH OF STAY IN 1b: few hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington, ~~D.C.~~ N.C. — COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, ~~D.C.~~ N.C.
d. STREET ADDRESS: 426 E. 3rd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Will — Middle: Elbert — Last: Sneed
4. DATE OF DEATH: Month: 10 — Day: 16 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-7-1873 — AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Sam Sneed
14. MOTHER'S MAIDEN NAME: Jeannie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: few hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Cerebral Arteriosclerosis

DUE TO

(c): Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year ——— 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 16, 1957, to October 16, 1957, that I last saw the deceased alive on October 16, 1957, and that death occurred at 9:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-21-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Grove Cem
22d. LOCATION (City, town, or county) (State): Washington N. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Clara D Lively — ADDRESS: 66 W Bare St
24a. REC'D BY REGISTRAR DATE: OCT 18 1957
24b. REGISTRAR'S SIGNATURE: A M Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN- The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with [illegible] the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10246

CERTIFICATE OF DEATH

10239

Reg. Dist. No. 8

1 PLACE OF DEATH
a COUNTY: A. A. County — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville Md
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hospital

2 USUAL RESIDENCE (Where deceased lived? If institution: Residence before admission)
a STATE: Maryland — b COUNTY: A. A. County
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville Maryland
d STREET ADDRESS
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): (First) Carol (Middle) (Last) Sparrows
4. DATE OF DEATH: Month 10 Day 15 Year 1957

5 SEX: Female
6 COLOR OR RACE: Colored
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 4-11-1952
9 AGE (In years last birthday): 5 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months | Days | Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: Paul Sparrows
14 MOTHER'S MAIDEN NAME: Dorthy Belt

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify war or dates of service): No
16 SOCIAL SECURITY NO: —
17 INFORMANT: Paul Sparrows — Address: Millersville Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Leukemia — INTERVAL BETWEEN ONSET AND DEATH: Approx. 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 10-15-1957 to ____ 19____, that I last saw the deceased alive on 10-15-1957, and that death occurred at 10:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Faye W. Allen M.D. — ADDRESS (Street, city or town, state): 62 Cathedral St. — DATE SIGNED: 10-18-57
PHYSICIAN'S NAME (Type): Faye W. Allen — 62 Cathedral St

22a BURIAL, CREMATION, REMOVAL (Specify): Buried
22b DATE THEREOF: 10-21-57
22c NAME OF CEMETERY OR CREMATORY: Elkridge
22d LOCATION (City, town, or county) (State): Elkridge, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II - Cora. Md. — ADDRESS:
24a. REC'D BY REGISTRAR DATE: 10/21/57
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely [illegible] by the funeral director page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10247

CERTIFICATE OF DEATH

10240 M

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: A.A. — MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Md. b. COUNTY: A.A.

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orchard Beach

c LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): XO Orchard Beach

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: I2I4 Riverside Drive

d. STREET ADDRESS: I2I4 Riverside Dr.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First HARRY Middle A. Last SPECHT

4 DATE OF DEATH: Month IO/9/57 Day Year 19

5 SEX: M

6. COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/8/I7

9 AGE (In years last birthday): 40 yrs

IF UNDER 1 YEAR Months / Days / IF UNDER 24 HRS. Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Pa.

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry H.

14. MOTHER'S MAIDEN NAME: Sarah Pope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO

17 INFORMANT Address: Family - Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Arteriosclerotic Cardio-vascular disease — 1 year

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myxedema - 10 yr duration. Cyst of the Pituitary Gland. Hodgkin Disease. Ant abdominal hernia 40 yrs.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1 19.30, to October 9, 1957, that I last saw the deceased alive on October 7, 1957, and that death occurred at 5:45 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: R.M. McLaughlin M.D. ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena, Md. DATE SIGNED: Oct. 9, 1957

PHYSICIAN'S NAME (Type): R.M. McLaughlin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b DATE THEREOF: IO/I2/57

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn

22d. LOCATION (City, town, or county) (State): Baltimore

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: McCully Funeral Homes - I30 E. Fort Ave.

24a. REC'D BY REGISTRAR DATE: 10 1 57

24b. REGISTRAR'S SIGNATURE: L.J. Dillehay

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) 1SM 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10180 **CERTIFICATE OF DEATH** 10241 21
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: A. A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. A. General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md.
d. STREET ADDRESS: 135 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mabel — Middle: E. — Last: Spriggs
4. DATE OF DEATH: Month: 10 — Day: 11 — Year: 1957
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-5-1897
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid
10b. KIND OF BUSINESS OR INDUSTRY: Mrs. Keener
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William Brashears
14. MOTHER'S MAIDEN NAME: Margaret Queen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO.:
17. INFORMANT: Stephen Spriggs — Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Intra Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
443X
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Arterio-sclerotic
DUE TO (c): Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/10 1937 to 10/11/57 19 that I last saw the deceased alive on 10/11 19 57, and that death occurred at 4:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. L. Richardson MD
ADDRESS (Street, city or town, state): 110 CLAY STREET ANNAPOLIS, MD.
DATE SIGNED: 10/11/57
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-15-57
22c. NAME OF CEMETERY OR CREMATORY: Bruer Hill
22d. LOCATION (City, town or county) (State): Annapolis Md.
23. FUNERAL DIRECTOR'S SIGNATURE: William Keene, E. Anna. Md.
ADDRESS:
24a. REC'D BY REGISTRAR DATE: 10/14/57
24b. REG'STRAR'S SIGNATURE: Wm. J. Franks

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10248

CERTIFICATE OF DEATH

10242
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY: AA Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: 4 yrs

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: AA Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Green Haven
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

3. NAME OF DECEASED (Type or print): First Jesse, Middle Lawrence, Last Stanks

4. DATE OF DEATH: Month Oct, Day 30, Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 28-1902
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): West Va
12. CITIZEN OF WHAT COUNTRY? U S a

13. FATHER'S NAME: Jesse L Stanks
14. MOTHER'S MAIDEN NAME: Mamie Kreiner

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT (Address): Bertha Stanks

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the lung — INTERVAL BETWEEN ONSET AND DEATH: 3 months
163X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from Feb 19 1955 to October 30 1957 that I last saw the deceased alive on October 29 1957, and that death occurred at 1:05 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: R. M. McLaughlin M.D. ADDRESS (Street, city or town, state): Pasadena, Md DATE SIGNED: Oct. 31 1957
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 2 '57
22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
22d. LOCATION (City, town or county) (State): Belair Rd Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard A Trinkle ADDRESS: Riley Bussard Md
24a. REC'D BY REGISTRAR DATE: Nov 1 1957
24b. REGISTRAR'S SIGNATURE: Louis LeAlbee

E J

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the Funeral Director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with in 72 hours after death.

YS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10249 **CERTIFICATE OF DEATH** 10243

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sophia — Middle: Alice — Last: Steiner

4. DATE OF DEATH: Month: Oct. — Day: 12 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 22, 1875

9. AGE (In years at last birthday): 82 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Shoemaker

14. MOTHER'S MAIDEN NAME: Sarah H. Eyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: David Steiner — Address: Jessups, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hypertensive Cardio-Vas. — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO (b): Disease with Cardiac Congestion — 2 wks.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour, a. m. / p. m.

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 19 56 to Oct. 12 19 57, that I last saw the deceased alive on Oct. 12 19 57, and that death occurred at 8:20 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank E. Shipley, M.D.
ADDRESS (Street, city or town, state): Sharpsburg, Md.
DATE SIGNED: 10-13-57
PHYSICIAN'S NAME (Type): Frank E. Shipley, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 16, 1957
22c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Frederick, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. E. Clemson
ADDRESS: 8 E. Patrick St., Frederick, Md.
24a. REC'D BY REGISTRAR DATE: 15 Oct. 1957
24b. REGISTRAR'S SIGNATURE: Clara Hockley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed by the funeral director page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10250 **CERTIFICATE OF DEATH**

10244 54
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Main Drive & Meadow Rd.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach
d. STREET ADDRESS: Main Drive & Meadow Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First LILLIAN Middle M. Last STINDT

4 DATE OF DEATH: Month 10/14/57 Day Year 19

5 SEX: F

6. COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/25/83

9 AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? Rhoades

14 MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17 INFORMANT: Family - Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours.
420.1
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year, Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from October 14, 1957 to October 14 1957, that I last saw the deceased alive on October 14, 1957, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.M. McLaughlin M.D. — ADDRESS (Street, city or town, state): 1248 Bonner Pasadena, Md. — DATE SIGNED: Oct 14 1957

PHYSICIAN'S NAME (Type): R.M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: 10/17/57

22c. NAME OF CEMETERY OR CREMATORY: Holy Cross

22d LOCATION (City, town, or county) (State): Baltimore

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully Funeral Homes - 130 E. Fort Ave.

24a. REC'D BY REGISTRAR DATE: OCT 16 19

24b REGISTRAR'S SIGNATURE: K. J. McAlley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completed by the attending physician and completed by the funeral director
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director post should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

T. C. 11 Film 0221 10-17-57 et

CERTIFICATE OF DEATH

10245

Reg. Dist. No.

10251

1. PLACE OF DEATH

COUNTY AA — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bar Harbor

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY AA

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bar Harbor

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Sylvia F. Stokes

4. DATE OF DEATH (Month) 10 (Day) 10 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
F	W	Married	5/14/06	51 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Walter A. Geary	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT & ADDRESS
No		Family Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSE(S) DUE TO (B) Cancer of the cervix of uterus about 4 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from June 18, 1957, to October 8, 1957, that I last saw the deceased alive on Oct. 8, 1957, and that death occurred at 6.10 A.M., from the causes and on the date stated above

SIGNATURE Glenn P. Hodack M. D. ADDRESS (Street, city, town, state) 205 Hampton Rd Lutherville Md. DATE SIGNED Oct. 10, 1957

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/12/57	Zion Lutheran Cem.	Stemmers Run, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
OCT 11 19	T. J. A. Allen	McCully Funeral Homes 130 E. Fort Ave.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The ... copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit

VS A15C 1-55 10M

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10246

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10181

Reg Dist No 21

1. PLACE OF DEATH a COUNTY A.A. Co. MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNapolis
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A A Hospt.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE WASH. DC b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d STREET ADDRESS 322 Prospect Pl — N.W. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ADELBERT Middle G. Last Thompson
4. DATE OF DEATH Month 10 Day 17 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 25, 1890
9. AGE Last birthday 67 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOTORMAN-Retired
10b. KIND OF BUSINESS OR INDUSTRY A.C. Transit
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John H. Thompson
14. MOTHER'S MAIDEN NAME Mary Dawson.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes If yes, give war or dates of service WW I
16. SOCIAL SECURITY NO. 578-10-7481
17. INFORMANT Address John A Thompson, Son.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart disease
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH Sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS A TOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town, (County) State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E. Linhardt
EXAMINER'S NAME (Type) E. Linhardt
M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 10/17/57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/22/57
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.
22d. LOCATION (City, town, or county, State) Ft. Myer, Va.
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS W.W. Chambers Co, Wash, D.C.
24a. RECEIVED BY REGISTRAR DATE OCT 21 1957
24b. REGISTRAR'S SIGNATURE [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal and in any event within 72 hours after death.

VS ATSME 4M 2 57

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10252

10247

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg Dist No 7-1

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Ferndale
c LENGTH OF STAY IN 1b: 10 years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3 Ferndale Avenue

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Same — b COUNTY: Same
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): X Same
d STREET ADDRESS: Same
e IF OF FARM: YES ☐ NO ☒

3 NAME OF DECEASED (Type or Print): First Raleigh — Middle I. — Last Timson

4 DATE OF DEATH: Month October — Day 24th. — Year 19 57

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 5/14/87
9 AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Brattleboro, Vermont.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Richard H. Timson
14 MOTHER'S MAIDEN NAME: Nannie Carter

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): No
16 SOCIAL SECURITY NO:
17 INFORMANT — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Self inflicted wound to the brain with a 32

976 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): gauge revolver.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒X

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.: Shot himself in the right temple.(32 gauge revolver)

20c TIME OF INJURY: Hour 7.05 a m / p m — Month Oct — Day 24 — Year 57 19
20d INJURY OCCURRED: White at work ☐ Not white at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f (City or town) Ferndale — (County) A.A. — (State) Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒X and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D.
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.
M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/24/57

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 10/28/57
22c NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
22d LOCATION (City, town, or county) (State): Woodlawn, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Thos. J. Tickner & Sons
ADDRESS: Catonsville 17, Md.
24a RECD BY REGISTRAR — DATE: 10/28/57
24b REGISTRAR'S SIGNATURE: L. J. Dalby

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the Local Board of Health or registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATAME SM 2 57

1

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

YS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10253

CERTIFICATE OF DEATH

10248

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLERSVILLE
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SANN'S NURSING HOME

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA MOUNT PLEASANT BEACH
d. STREET ADDRESS: MT PLEASANT BEACH
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD Middle SMITH Last TYLER

4. DATE OF DEATH: Month OCT. Day 13 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 19, 1871

9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED WATERMAN

10b. KIND OF BUSINESS OR INDUSTRY: SHIPPING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: OLIVER B. TYLER

14. MOTHER'S MAIDEN NAME: MARTHA HEWITT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO: 218-09-0184

17. INFORMANT: MRS. JOHN SCHMIDT Address: PASADENA, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CARCINOMA BLADDER — INTERVAL BETWEEN ONSET AND DEATH: 2 YEARS

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JULY, 1956, to OCT. 13, 1957, that I last saw the deceased alive on OCT. 9, 1957, and that death occurred at 11:40 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: J. Brady Smith M.D

ADDRESS (Street, city or town, state): RIVIERA BEACH, MD.

DATE SIGNED: 10/13/57

PHYSICIAN'S NAME (Type): J. BRADY SMITH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-16-57

22c. NAME OF CEMETERY OR CREMATORY: PARSONS

22d. LOCATION (City, town or county) (State): SALISBURY Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George L Schmal ADDRESS: 2101 Fruitland Ave Salis. Md.

24a. REC'D BY REGISTRAR DATE: OCT 15 '57

24b. REGISTRAR'S SIGNATURE: H M. Joyce

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10182

CERTIFICATE OF DEATH

10249

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hosp

2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shady Side
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Fernando / Middle: / Last: Weems

4 DATE OF DEATH: Month: October / Day: 8 / Year: 1957

5 SEX: Male

6 COLOR OR RACE: W

7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 10/23/1887

9 AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSPECTOR

10b KIND OF BUSINESS OR INDUSTRY: AA Co. Health Dept

11 BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY?: U.S.

13 FATHER'S NAME: Wilson T. Weems

14 MOTHER'S MAIDEN NAME: Ida V. Hartge

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16 SOCIAL SECURITY NO: —

17 INFORMANT: Mrs. Weems — Address: #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

410.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Chronic over exertion. — Years?

DUE TO (c): Probable Peptic Ulcer — 2 Mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old myocardial infarction 1½ years

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year — 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1956 to 5 October, 1957 that I last saw the deceased alive on 30 October, 1957, and that death occurred at 7:40 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Franklin D Hendricks M.D. — ADDRESS (Street, city or town, state): Shady Side, Md. — DATE SIGNED: 10/9/57

PHYSICIAN'S NAME (Type): Franklin D Hendricks

22a BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10/10/57 — 22c. NAME OF CEMETERY OR CREMATORY: Quaker Burying Ground — 22d. LOCATION (City, town, or county) (State): Galesville, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: 10/10/57 — 24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10183

CERTIFICATE OF DEATH

10250

Reg. Dist No

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 9C9½ West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: Ray — Last: Whitaker
4. DATE OF DEATH: Month: 10 — Day: 15 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 3, 1956
9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Luther Whitaker
14. MOTHER'S MAIDEN NAME: Betty Greer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: — —
17. INFORMANT: Luther Whitaker — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Sudden C.N.S. vasomotor collapse — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Stress with febrile reaction — 4½ hrs.
DUE TO
(c): Burns, superficial, 1st & 2nd degree, face & chest — 24 hrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None Known or suspected
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Accident - baby tipped over cup hot water, scalding self
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 12:30 p.m. 10-14 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State): AA

21. I certify that I attended the deceased from Oct. 14, 1957 to Oct. 15, 1957, that I last saw the deceased alive on Oct. 15, 1957, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Merton T. Waite M.D. — ADDRESS (Street, city or town, state): Cathedral & Dean Sts. Annapolis Md. — DATE SIGNED: 10-15-57

PHYSICIAN'S NAME (Type): Merton T. Waite, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 10-16-57
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county): Abington (State): Va.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Taylor & Sons — ADDRESS: Annapolis, Md.
24a. RECD BY REGISTRAR DATE: 10/16/57
24b. REGISTRAR'S SIGNATURE

Coroner Dr. Elmer Richardson notified

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove page 3 for papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10251

CERTIFICATE OF DEATH

10254

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR MEDICAL EXAMINER: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Plaza Manor Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn Station
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) ALICE (Middle) WHITTINGTON (Last)

4. DATE OF DEATH (Month) Oct (Day) 15 (Year) 1957

5 SEX	6 COLOR OR RACE	7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9 AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
F	C	Wid.	6-29-1884	73 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maid	Private Family	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Gimbrilles	Susan Bayne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Yes	—	Isabel J. Watts Annapolis, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
X IMMEDIATE CAUSE (A)	Hypertensive vascular disease	
ANTECEDENT CAUSE(S) DUE TO (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (C)		

b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20 AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED White at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1957 to Oct 15, 1957, that I last saw the deceased alive on Oct 12, 1957, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

SIGNATURE Joseph Talet M.D. ADDRESS (Street, city town, state) 102 Bd A Blvd. N.E. Glen Burnie, Md. DATE SIGNED 10-16

23 BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-20-57	Carpenters Hill	Round Bay Md.

24. REC'D BY REGISTRAR DATE 10/22/57	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
		William Reese Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10255

CERTIFICATE OF DEATH

10252

Reg. Dist. No. 27

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Mississippi
b. COUNTY: Yazoo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Yazoo
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Willie — Middle: V — Last: Williams

4. DATE OF DEATH: Month: October — Day: 3 — Year: 1957

5 SEX: Male

6. COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 30 September 57

9 AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months | Days: 3
IF UNDER 24 HRS.: Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Wilbert Lee Williams

14 MOTHER'S MAIDEN NAME: Georgia Lue Johnson

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17 INFORMANT — Address: Father, 104 King Court, Dundalk, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Prematurity Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 3 days

776X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 30 Sep 57, to 3 Oct 57, that I last saw the deceased alive on 30 Sep 57, 19—, and that death occurred at 1:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank L. Gruskay M.D. — ADDRESS (Street, city or town, state): USAH, Fort G. G. Meade, Md. — DATE SIGNED: 3 Oct 57

PHYSICIAN'S NAME (Type): FRANK L. GRUSKAY, MD

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct-7-1957

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d LOCATION (City, town, or county) (State): Frederick Road Catty Sup

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Earl B Roberts Funeral Home 6306 Reisterstown Rd Baltimore 15 Md

24a REC'D BY REGISTRAR DATE: 3 Oct. 57

24b REGISTRAR'S SIGNATURE: Wilbur H. Downs, Jr. Capt. MSC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page(s) should be detached for use as the burial-transit permit. Then please remove carbon papers. Page(s) and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G221 10-11-57 et

10256

CERTIFICATE OF DEATH

10254

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE, Md.
c. LENGTH OF STAY IN 1b: 2 yrs, 5 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CROWNSVILLE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md. — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Unknown
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER — Middle — Last WILSON

4. DATE OF DEATH: Month Oct. — Day 5 — Year 1957

5. SEX: M

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ ✓ DIVORCED ☐

8. DATE OF BIRTH: Unknown — Appx.

9. AGE (In years last birthday): 60 + yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: EDWARD WILSON

14. MOTHER'S MAIDEN NAME: Adeline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: — —

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): RENAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: Few hours

260 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ACUTE + CHRONIC PIELONEPHRITIS — 2 mos-

DUE TO (c): DIABETES MELLITUS — 2 yrs-

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 6, 1955, to Oct 5, 1957, that I last saw the deceased alive on Oct. 5, 1957, and that death occurred at 3:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Conwell Newton M.D. M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital — DATE SIGNED: 10.5.57

PHYSICIAN'S NAME (Type): CONWELL NEWTON

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 10-10-57

22c. NAME OF CEMETERY OR CREMATORY: W. Grad. Med. School

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Kaas — ADDRESS: #108 Wash. St. Conn. Md.

24a. REC'D BY REGISTRAR DATE: OCT 14 1957

24b. REGISTRAR'S SIGNATURE: R. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10184

CERTIFICATE OF DEATH

10255
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Edgewater
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Florine — Middle — Last Wood

4. DATE OF DEATH: Month 10 — Day 3 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-2-1957

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alvin C. Wood

14. MOTHER'S MAIDEN NAME: Dorothy Ours

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Alvin C. Wood — Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) [redacted] pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
763.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 2, 19 57, to Oct 3, 19 57, that I last saw the deceased alive on Oct 2, 19 57, and that death occurred at 6 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil H. Sims M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10-3-57 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff — 22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Poulsons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: 10/4/57 — 24b. REGISTRAR'S SIGNATURE: [redacted]

20633O6XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55